			State of Maryland / Dep		nd Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	1	Reg. No.2	09	36001
	Physicia		Ecoest R Hube		2. Date of Dead		Year 2	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D		4c. County		
L		-	Baltimore Washington Med Ctr	Glen Burn	ie			undel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 2.1.9 – 1.8 – 7.2.1.1	If Under 1 Year If Under 24 Months Days Hours		th y, Year)	Count	lace (State or Foreign
	Director		219-18-7211		Min. 05/26	/1925	LMai	yland
back	shov	tor	10a. State 10b. County 10c. City, Town or L	ocation			1	0d. Inside City Limits
Man	28a-1	irec	MD Anne Arundel Pasa					1 🗌 Yes 2 🖼 No
4	3a or	ral D	10e. Street and Number	10f. Zip Code		10g. Citizen of		
4	ems	Funeral Director	188 Carroll Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21122 Was Decedent of Hispanic Origin	? (Specify Yes or No-		U.S.A	
စ္က	or it	þ	1 Never Married 2 Married Armed Forces? 1943 –	If Yes, specify Cuban, Mexican, F 1 ☐ Yes 2 ☑ No Specify:	uerto Rican, etc.)	Bla	ck, White, e	etc.
nd 21215-0036	The factor of the walls of the factor of the factor of the wall the way and the factor of the factor	Completed	3 We wildowed 4 Divorced Year or Dates.			Specify		
3735-0036	an "na Medic	mple	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	f working	16b. Kind of B	usiness Inc	lustry
717	giene giene er the		Lienteritary/Seconday (0-12) College (1-4 of 5+)	lesman		Re	tail	
יום	tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's	s Name (First, Middle,		e)	
Maryland	and Men and Men is marke raumatic	_	Edward Hube 19a. Informant's Name/Relationship (Type, Print) 19b. Mai		Anna Sh			
	Lith and 27 is m			ing Address (Street and Number of Deering Road				
e, j	of Health fitem 27 rother tr		20a. Method of Disposition 20b. Place of Disp		Date Date	20c. Location		
altimore,	ment of ant. If any or		TE Buildi E E Grennation o E Hemoval nom otate	idge Mem Pk 1	1/03/09	Balt	imore	e. MD
Balt	Department of Important: If it any injury or conce.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility	G.J.Gono	e Fune	ral	Home, PA
	10 = 6 6		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	169 Riviera D			i, MD	Approximate
~ DI	nysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		and or respiratory at			Interval Between Qnset and Death
1	Medical		disease or condition resulting in death) a. Due to (or as a consequence of);	ना रवापा	1 1 1	11 1-	1 -	days
· ·	Examiner Sequentially list conditions, b. Acute Interstitud Nephritis							
70	sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or ininjury			/		
xecute	n and al-tran	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
50	physician and the burial-transit	dicat	d					
	ing ph	Mec	IF FEMALE:					
DOX C	attend for use	cian/	23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy Other (specify)			ate of delive	ery Day Year
Je ge	y the	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)				
ר װ ט װַ	ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.				ne cause of death?
ds,	en sig	ted			1 🗆	Yes 2 No	3 🗌 Prot	oably 4 🗆 Unknown
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VITA	is certi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Lou	sina Home 5 🗀 Resi	dence 6 🗆 Oth	er (Specify)
o 5	fter th		27. Manner of Death 128a. Date of injury (Month, Day, Year) 28b. Time (Month, Day, Year) injury			now injury occur		
NOI:	death. tor: A the fu	Certificate:	2 Accident Investigation	M 1 🗌 Yes 2 🗍 N				
DIVISION OT	after Direc	Cer	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	геет, тастогу, опісе	28f. Location (City or Tov	Street and Numb vn, State)	er or Hural	Houte Number,
⊒ Siuso	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	occured at the time, date and pla	ace, and due to the ca	use(s) and man	ner as state	id.
the H	thin 24 the F	Me	only one) 3 Certifying Hurse Practioner: To the best of my knowledge	death occurred at the time, date as		ne cause(s) and m	nanner as st	ated.
٦	S 5 8		29b. Signature and title of certifier	29c. License number	-,-)	29d. Date signe	he j	5 7 80 9
	1+1		80. Name and address of persop who completed cause of death (Item 23a) (Type,	Print)	> 0	1 0	1	1) (2)
	I ∨		 2 usel Ol Delucano - 	DOS HOSPITA	1 Stirt (How In	1 Mel	-01061
	Star Registra		31. Date filed (Month, Day, Year) 32. negistrar's Signature	based				
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MortemBER MINNIE IRENE HERMAN 5-40 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ILEN BURNIE TEP JASKIM GOOD MEDICAL ARUNISEL ANME SALTI MORE Social Security Number If Under 1 Year 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🗹 F Months Days Hours Min 2/2 8ay Director 217-12-7657 Marvland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗹 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 935 Lombardee Circle 21060 U.S.A. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 MWidowed 4 ☐ Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manager Drug Store Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be Walter A. Hoffman Emma L. Dorter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Pintail Court, Glen Burnie, MD 21060 <u> Thomas Burnham / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk: 11/09/09 Baltimore, per mit. Signature of Euneral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, <u>Riviera Drive, Pasadena, MD 21122</u> 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. REBRONASCIL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Vatural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 24 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge coatr. ed at the time, date and place, and due to the cause(s) and manner as stated Name and address of person who completed of use of death (Item 23a) (Type, Print) Glew Burnie Mi)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 5:00 P M Margaret Ann Hines November 5, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Transitions Health Care Sykesville Carroll If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day,)
Jan. 30, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Year) 1918 **Funeral** Days Months 212-09-7450 1 □ M 2 🔀 F 91 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is it will disal event in it is the multified at another. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Carroll Sykesville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2360 Jim Kohler Road 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ∐Yes 2√∑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo SpecifyWhite δ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Karl ഉ Anna Schlee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Reed Daughter 2360 Jim Kohler Road, Sykesville, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Moreland Memorial 11/09/2009 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Burgee—Henss—Seitz Funeral Home, Inc. 21211 21. Signatura of Funeral Service Lice 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CardioVoschlar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on: To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day been signed by the should be detached 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? iis certificate has t director, page 2 s autopsy performe 2 🗆 No 1 □ Yes 2 XN0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 | Aursing Home 5 | Residence 6 | Other (Specify) cthis c 1 | Yes 2- PNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 43725 30. Name and address of person who completed cause of death (Item 23a) (7) pe, Print) ALMOUD 31. Date filed (Month, Day,

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36004

			1 - State Of State Of Registrar	Ce	rtificate of		vientai myg R	2009	36004
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	/Medic		William Henry Hall,				11	07 2009	9 2:30 P M
3	Examin	ier	4a. Facility Name (If not institution, give street and numb	per)		or Location of Death		4c. County of Dea	
	E	-	6227 Chestnut Oak Lane 5. Social Security Number 6. Sex 7	Age (In yrs. last birthday)	Lin	thicum	8 Date of Birth		e Arundel
l.	Funeral Director		213-30-1688 1M 2□F Usual Residence of Decedent	75 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 01/23/1		rthplace (State or Foreign Country) MD
	dand ow		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sh	ţō	MD Anne Arundel		G1 ₀	n Burnie			1 □ Yes 2 ∏ No
	th the	Director	10e. Street and Number		10f. Zip Code	ii Duliile	1	0g. Citizen of What Co	ountry?
	23a	ral	300 Blue Water Court	Unit 103		21060		U.S	S.A.
	er de	Funeral	11. Marital Status 12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
215-0036	s filed within 72 hours after death with the Maryland It hygiene, other than "natural", or items 23a or 28a-f show vent, the Medical Expenies must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date		1 □Yes 2√∑No	Specify:		Specify:	White
<u>.</u>	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occu kind of work done	pation during most of work id)	ing	16b. Kind of Business	/Industry
121	within ene. than '	m d	Elementary/Secondary (0-12) College (1-4	01 5+)				T 73	-
d 27	filed v Hygid ther	ပိ	12 17. Father's Name (First, Middle, Last)		Police /	Security 18. Mother's Name	e (First, Middle, N		forcement
Maryland	ld be ental ked c	To Be	William Henry Hall, Sr.					a Krammer	
ar <	shou and M s mar umat	۲	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number	City or Town, State,	Zip Code) 21060
Ž	and 2 fealth am 27 is her tra		Mrs. Arline S. Hall / wi	,		er Court			Burnie, MD
o e	es 1 a of He fiter		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other pla	ce)		20c. Location - City or	
Ĕ	Pag ment ant: I	l ķ	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ite	Cremato		0/09	Glen Burni	le, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event, ance.		21. Signature of Funeral Service Licensee	25	2. Name and Addre	ess of Facility 1			en Burnie, MI
_			Mark le. Varen	MO1357 S	ingleton	Funeral	& Cremat	ion SErvic	
		į.	23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	h line.			or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician / /Medical	1	Immediate Cause (Final disease or condition resulting in death)	PHACEAL	- CAN	CER			Oriset and Death
	Examiner		Due to (or	as a consequence of):					
		ner	Sequentially list conditions, if any leading to immediate Due to (or	as a consequence of					
	od d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
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8/60,	rtificate be executed ng physician and as the burlal-transit	lical	d						
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0.00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		h 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		23d. Date of de Month	elivery Day Year
7.	that ned by deta		Part II. Other significant conditions contributing to deat	h but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	to the cause of death?
ecords,	equires sen sigi outd be	ted by					1 □ Ye	s 2 No 3 P	Probably 4 🗹 Unknown
ပို့	law r nas be s 2 sh	Completed					24a. Was ar		utopsy findings available completion of cause of
<u> </u>	: The cate ?	S					perform 1 □ Yes 2	ned? death?	s 2 No
N I G	lcian certifi ector	Be	25. Was case referred to medical examiner?		100	26. Place of Death	h (Check only one	9)	dayah tara l
5	Phys rthis ral dir	P.	1 ☐ Yes 2 ☐ No 1 ☐ Inp 27. Manney of Death 28a. Date of	atient 2 ER/Outpatier		4 LI Nursing Ho		nce 6 TOther (Spe	daughter' residence
SION	ding h. After fune	tion	1 Natural 5 Pending (Month, 2 Accident investigation	Day, Year) 200. Time o	Wor	k? Yes 2∐No	28a. Describe no	w injury occurred	
2	Attence er death ector: by the	fica	3 Suicide 6 Could not be	Injury - At home, farm, str			28f. Location (St	reet and Number or R	Rural Route Number.
5	al or	Certification:	4 Homicide determined building	etc. (Specify)	•		City or Town	, State)	,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the besence the control of the contr	s of examination and/or in	h occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and manner a	us stated. e to the cause(s)
	No the	Me	29b. Signature and title of certifier		29c. Licens	se number	25	9d. Date signed (Mont	th, Day, Year)
			· allma Kuhnin	MA	D	21336		11/9/0	,9
			30. Name and address of person who completed cause of the cause	death (Item 23a) (Type,		19, SUITE1.	34 PASI	LDENA M	D 21122
	Stat Registra			strar's Signatu	GA PAR	//	- // - //	7.	₩

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month F 4, 200 4c. County of Death ovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner omewoo 8. Date of Birth (Month, Day) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) **Funeral** Days Min 87 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 Yes 2 □ No Funeral Director more 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be in Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 NNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 12. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify. Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 00 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 7 Be t and 2 should be the alth and Mental 9 ence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Z 1 D 6 0 19a. Informant's Name/Relationship (Type. Print) Ldaughter Pages 1 and 2 len Burnie Department of Healt Important: If Item 2 any Injury or other once. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral ve. Bul Joseph Home AVE. North TO. 23a. Part1. Inter the disease, of complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 450 **Physician** hea /Medical Due to (or as a consequence of) Examiner Site Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trans Due to (or as a consequence of) physician a Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 → NO 3 □ Probably 4 □ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has je 2 page, performed Vital certificate 1∐ Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o After this 28a. Date of Injury (Month, Day Year) funeral 27. Mann T Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Division Watural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the i 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /3 0 301 5 de athun 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 51 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Examiner Town or Location of Death County of Death Baltimore Mashinata n vrs. last birthday 8. Date of Birth If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 1 M 2 - F Months Days Hours Min Director Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 No More Street and Number ò 10f, Zip Code 10g. Citizen of What Country? 23a permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked Alternate any injury or Alternate. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 Yes 2 No 3 ₩idowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Deleanor Harris-Boone 8 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa are of Funeral Service License 22. Name and Address of Facility Funeral Itomo, 28 23a. Part 1. Inter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ myowrdul interete disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 phy: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural iniury 5 Pending 24 hours after death. Funeral Director: A Accident
Suicide Investigation filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical within 24 hou

To the Fune

completed fil 29a, Certifier 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kichend C Bery 20020604 11/9/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's signature

Richard A Berg. aD; Svite 450; 10755 Fells Rd, Lutherville, Ad 21093

homas Dixon I	nsle	1- For State Registrar	of Maryland / D	Department Certificate			Mental H	F	109.110.	009	
Physici ledical Exami		1. Decedent's Name (First, Middle, La Thomas Di	st) xon Insley	7				2. Date of Dea Month November	ath Day Year er 5, 2009		3. Time of Death 1425 hrs
		4a. Facility Name (if not institution, gi			4b. City, T		ocation of Death		4c. County o		ity
Funeral Director		5. Social Security Number 6. S	Sex 7. Age (III	n yrs. last birthday)		er 1 Year	If Under 24Hrs Hours Min		irth(MM/DD/YYYY)	9. Birth Foreign	place (State or
Á		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo				рере	20,133	Y	10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	'n		imore	•	sex						1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 24 Nerbay Ro	ad		10f. Zip	Code 2122	1		10g. Citizen of Wh	at Count	ry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marrie 3X Widowed 4 Divorce		No I	f Yes, specif		anic Origin? (S Mexican, Puerto specify:		White		an Indian, Black, te
11215-0036 Id be filed within 72 hours aft fental Hygiene. narked other than "natural" event, the Medical Examin	ompleted by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	or Dates:	ted) 16a. Deced	ient's Usual	Occupation	on (Give kind of DO NOT use ret		16b. Kind of Bus	siness/In	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than matic event, the Medica	ပ	17. Father's Name (First, Middle, Las	,			18		,	, Maiden Surname)		
2121 rould be fill id Mental I is marked tic event,	To Be	Wilbur Ins 19a. Informant's Name/Relationship (Type, Print)	41	_	,	and Number or		ımber, City or Towr		
		Margaret Smit 20a. Method of Disposition	h /daughte	20b. Place of Disc	osition (Nar	ne of cem	etery,	ue Bal	Ltimore 20c. Location -		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 4 Donation 5 Other Specif		Garrisc	other place)	rest	11	/9/09	Owings	s Mi	.lls MD
Baltimo permit. Page Department of Important: injury or oth		21. Sign iture of un ral Service Lio	nsig()		2. Name and				ce Ave.		
Physician /Medical	w w	23a. Part I. Enter the disease, of corr failure. List only one cause on e	each line.			of dying, s	uch as cardiac	or respiratory a	rrest, shock, or hea	art	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic Ca		Disease						Death
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):							
uted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							
60, tte be executed sysician and burial - transit	ledical	UNPENDED	AMENDED						(ACT AND		
Box 68760, death certificate by the attending physic df for use as the bur	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live birth 4 Pregnant at time	2	Fetal death Other (Spe	3 cify)	Ectopic pregn	ancy	23d. Date of Month		ay Year
). Bo t the deat by the at ached for	Phys	1 Yes 2 No 9 Unknow Part II. Other significant conditions	9 Olikilowii	ut not resulting in th			ven in Part I.	23e. Did	tobacco use contri	ibute to t	he cause of death?
ires that the signed by	ģ	Chronic Alcoholism						1 _ Y	es 2 No 3	Proba	ably 4 🗸 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiti	Completed							perf	opsy p formed? o		opsy findings available ompletion of cause of S
Vital Recontrol Strain The land this certificate hall director, page 2	a	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpati			of Death (Check Other Nursi	only one)	Residence 6	ℓ Other:	Scene
n of V ding Phy After th funeral d	n: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Poording	28a. Date of Injury (Month, Day, Year)			28c. Injury	at Work?		e how injury occurr		
Division fal or Attendii rs after death.	Certification:	2 Accident 5 Pending Investiga 3 Suicide 6 Could no	28e Place of Injury	/ - At home, farm, s	treet, factory		es 2 No ilding, etc.			er or Rur	al Route Number, City
Divi Hospital or 24 hours afte Funeral Dir		4 Homicide determin	ed (Specify)					or Town,			
Division To the Hospital or Attenwifin 24 hours after death To the Funeral Director:	Medical	(Check only	cian: To the best of my kr er:On the basis of examin and manner stated.	_	gation, in my	y opinion,	death occurred		e and place, and d	lue to the	cause(s)
	ž	298. Signature and title of certifier			29	c. License O.C.N			29d. Date sign		
	(30. Name and address of person who	· -	, ,				204			
	tate	Laron Locke MD. Assi: 31. Date filed (Month, Day, Year)	stant Medical Exam		,	197	ore, MD 212	201			<u></u>
Regis		NOV 10	2009 Dener	u B.,	Bark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Month 3-2009 Dolly Carrie Jones 0200 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Japan **Funeral** 8. Date of Birth Days Hours 1 M 2 V F 1000030ay 1995 219-58-4507 Director 84 Usual Residence of Decedent 28a-f show 10a. State 10b County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 25a or 28a-f sho 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Bel Air 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 713 Mayton Court 21014 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Japanese Completed 3 Nidowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Gov't SSA Computer Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Minoru Okamoto Nobuko Miyauchi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Mayton Court Bel Air, MD 21014 Claire Jones (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BelAir Mem. Gardens 11-05-2009 Bel Air, MD 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Schimunek_Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition wee Icc Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease C. Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): iding physician and ise as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death
Unknown P.0. signed by the period of the period of the signal of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician; The law requires Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate 2 No Yes 1 Tes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death

1 Natural

20 Accident

3 Suicide funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completed filled in by the fu 1 🔲 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

0 State Registrar 3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title of certific

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Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Amend #26 per Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 36009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Estelle James November 06 2009 03:12 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 7727 Overhill Road Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 17 **Funeral** 1 □ M 2 3 F Months Days Hours Min. 220-18-3447 Director 83 1926 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Woolds Examinating at 1 ☐Yes 2 ☑ No Director Anne Arundel Maryland Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7727 Overhill Road 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2½∏No Specify: White ğ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Motor Vehicle Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Supervisor Administration marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Johnson Pauline Hickman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 is 1519 Galena Road, Essex, MD 21221 Darlene Berry (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11 Nov. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 2009 Glen Burnie, Maryland 21. Signature of Funeral Service Ucen ee 22. Name and Address of Facility and Address of Pacility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or or preditions that caused the shock, or heart failure. List of ly one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence off Examine The law requires that the death certificate be executed attending physician and for use as the burial-transil COROMA Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a d be detached for Pregnant at time of death 5 Other (specify) ☐Yes 2 ☑No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 1 24 hours after death. Funeral Director; After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence Residence မ 1 Yes 2 1√1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RANN K. RASTOGINV) 7.575 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			For State	State of Maryla				lental Hyg	iene		
			Registrar		(Certificate of	Death	2. Date of Deat	eg. No. 20	09	36010
	Physicia		1. Decedent's Name (First, Middle, Last)	es				Month	Pay ZI	007	1042AM
	/Medic Examin		4a. Facilify Name (If not institution, give si			4b. City, Town,	fr Location of Death	1000	4c. County	of Death	willy
		3	Vautage Ho	450		Cole	145 (5	<i>p</i>	H	26	201
	Funeral		5. Social Security Number 6. Sex	7. Age (In your 90)		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	, Year)	Coun	
	Director		215-22-7012 Usual Residence of Decedent			-		11/8/19	18	Tenne	essee
	nyland how		10a. State 10b. County		City, Town					1	0d. Inside City Limits
	ne Ma 8a-f s	ecto	MD Howard		Columb						1 X Yes 2 □ No
:	filed within 72 hours after death with the Maryland Hyglene. When than "natural", or items 23a or 28a-f show sht, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 5400 Vantage Poin	t Poad Ant :	#713	10f. Zip Code 21044		1	0g. Citizen of V		try?
į	hs 23	eral		2. Was Decedent Ever in Armed Forces?		13. Was Decedent of H	Hispanic Ongin? (Spe	ecify Yes or No-	14. Rac	ce - Americ	
0	after or iter		1 ☐ Never Married 2 🔀 Married	1 □Yes 2 TXTNo		If Yes, specify Cub		Rican, etc.)	Specif	ck, White,	
3	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10. 5					*****	
2	in 72 in 72 in 12	Completed	15. Decedent's Educ (Specify only highest grade	completed)		ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of work d)	ing	16b. Kind of B	usiness/inc	dustry
7 7	d with giene. rr thar the N	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		ntracting (I	Dept.of	Navy	/Air Force
2	sal Hyg d othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, I	Maiden Surnar	ne)	
7 2	2 should be and Mental is marked c raumatic ever	2	Hugh	2:0	100	Henley	Warner				Young
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ Harry Jones/ Husb	_ ′		Mailing Address <i>(Street</i> 00 Vantage					ia, MD 21044
υ.	s 1 and f Health Item 27 other tr		20a. Method of Disposition			Disposition (Name of crematory or other pla			20c. Location		
₽ ,	Pages nent of h int: If lte		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval nom State		Gifts Regist	1	0/2009	Hanove	er, Ma	aryland
<u> </u>	permit. Departn Imports any Inju		21. Signature of Euneral Service, License	• /	_	22. Name and Addre					
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			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	eath. Do no	t enter the mode of dyl	ng, such as cardiac	or respiratory arm	est,		Approximate Interval Between Onset and Death
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T CV	p it	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
,	ne death certificate be executed the attending physician and hed for use as the burial-transit	Examiner	that initiated events c. resulting in death) Last	sequence of);						
3	e be e sician s burit		d								
000	rtificat ng phy as the	Medic									
אַ מ	ath cer ttendir or use	Physician/Medical	23b. was decedent pregnant	lc. If yes, outcome pf pred 1 ☐ Live birth 2 ☐ F		3 ☐ Ectopic pregnanc	ÿ			ate of delive	ery Day Year
5	the deather the all	ysici	in the past 12,months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time o 9□Unknown	of death	5 ☐ Other (specify) _			1010	21101	Day Teal
ŗ.	Physician: The law requires that the death certificate be tribicate has been signed by the attending physician director, page 2 should be detached for use as the bur		Part II. Other significant onditions conf	ributing to death but not i	resulting in t	he underlying cause gi	ven in Part I.	23e. Did tot	bacco use con	tribute to th	ne cause of death?
colds,	quires an sigr uld be	ed by	emps/c	219				1200	es 2□No	3 ☐ Prob	ably 4 Unknown
כ ט	law re as bec 2 sho	Completed						24a. Was a	n 24b.	Were auto	psy findings available impletion of cause of
ב -	The cate h	Com						perform	med?	death?	2 No
) 	siclan certifii rector	Be	25. Was case referred to medical examiner?	ospital:		Oti	26. Place of Death				
5 i	Phys er this eral di	- To	1 Yes 2 No	28a. Date of Injury	28b. Tir	ne of 28c. Inju	Nursing Ho	me 5 Reside			y)
5	ath. r: Afte	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year	r) Inj		rk?]Yes 2 □No				
2	ir Affe ter dec irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - Albuilding, etc. (Spe	t home, farn	n, street, factory, office		28f. Location (St City or Town		ber or Rura	il Route Number,
ָ	To the Nospital or Attending Physician: The law requires that the dr within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		29a. Certifier 1 Certifying Phys	ician: To the best of my i	knowledge	death occurred at the t	ime date and place	and due to the	20100/01 024	annor co	tated
:	e Hos 124 hc e Fun letely	Medical		er: On the basis of exam and manner stated.							
1	Vithin To th comp	Me	29b. Signature and title of certifier	Mala		29c. Licen	se number		29d. Date signe	ed (Month,	Day, Year)
			vag	1010			4/6/7	- 1	NOU	6,	2007
	1		30. Name and address of person who con	npleted cause of death (I	tem 23a) (T	ype, Print)			, ,	1	2 1

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 6, 2009 7:27 P M RAYMOND SANTFORD JOHNSTON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 8. Date of Birth (Month, Day, Oct. 9, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1925 **№** M 2 □ F Months Days Hours Min. North Carolina 84 <u>246-28-6404</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21047 404 Merrie Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturer General Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosa Lee Hartzog Raymond Fletcher Johnston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Merrie Lane, Fallston, Maryland 21047 Eunice Johnston / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn | 11-11-09 Bel Air, Maryland 21. Signature of McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANGR WITT disease or condition resulting in death) Due to (or as a consequence of): MECHANIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE nancy 23d. Date of delivery tal death 3 Ectopic pregnancy Month Year Day f death 5 ☐ Other (specify) esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 3 DOA 4 Nursing Home 5 ☐ Residence ibe how in

Physician /Medical Examiner physician and the burial-trans

Physician

Examiner

Directo

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, II. Marical Evantant: ust be notified at once.

 $I/I \mathcal{U}$ Baltimore,

/Medical

Examiner Physician/Medical attending p signed by the a Completed by Be ို Certification:

The law requires that the death certificate

Hospital or Attending Physician:

this certificate

within 24 hours a

To the Funeral C

Records,

Vital

Division of

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 Live birth 2 Fe 4 Pregnant at time of
Part II. Other significant condition	s contributing to death but not re

examiner? 1 ☐ Yes 2	16
27. Manner of Death	
1 Natural	5 Pending
2 Accident	investigatio
3 Suicide	6 ☐ Could not b
4 ☐ Homicide	determined

Hos	spital:	1 Depatient	2 🗆	ER/O	utpatient	
	28a.	Date of Injury (Month, Day, Ye	ear)	28b.	Time of Injury	

		9 ' '	OITIE	JП,
ry at			28d.	Descr
Yes	2 🗌 No			

_			
6	Other (S	(pecify)	
ıry	occurred		

BELAIK, MD 21014

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

LAVUSHA	2.	Ri	THAN	
31. Date filed (Month,	Day,	Year)		32. Feg

60 GATEWAL egistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 8:30 Daris Clark Jones November A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 514 Eckert Drive Joppatowne Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 XM 2 □ F Days (Month, Day, Months Hours Min Maryland Director 48 1961 214-64-6134 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a, State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Harford Joppatowne 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21085 514 Eckert Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Master Electrician Electrical Construction ulth and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Herman Clark Jones June Ann Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ryan Clark Jones / Son 648 Harbor Side Drive, Apt. B, Joppatowne, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Highview Memorial Gdns. Nov.13,2009 Fallston, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. of Funeral Service Licensee 1317 Cokesbury road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CONTROC disease or condition resulting in death) Somogral Months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at Id be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes Completed 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed; After this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury death. 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F complet 32 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier License number 29d. Date signed (Month. Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) entoun istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 36013 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** Johnson 8:104 M Arah November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner - Dulaney Manor Care DWSDM Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye OUT 11 102 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Min 244.52.9899 1 □ M 2 💢 F 87 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore Pikesville 1 ☐ Yes → No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or items. Park Heights Avenue #203 21208 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Jursing Assistant Medical 11th arade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hadie Atkinson Bufflow Carrie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3828 Collier Road Randallstown MD 2113 Doris Bradle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Windor Mill, MD Membrial Park 22. Name and Address of Facility Vaushon C. Greene Funeral solice 21. Signature of Funeral Service Licensee Vau Road Randaustown MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 Y. r.1 disease or condition resulting in death) Athonoscherote /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of sician and burlal-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): signed by the attending physician and be detached for use as the burlal Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u></u> cate has been si page 2 should t 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate is completely filled in by the funeral director, pag of Vital 1 □Yes 2 1No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kiour 031861 mian -D

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

200

NOV 1 0 2009

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Spuntry)

Naryland 8. Date of Birth (Month, Day, Sex 1 M 2 □ F Age (In yrs. last birthday) **Funeral** Months Min Days Hours Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be refitted at once. 10d, Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 XYes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No 17 es, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: þ 3 Widowed 4 □ Divorced 1 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) han 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) Laughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 rmine 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State . Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 2009 3 Removal from State 22. Name and Address of Facility
JOSEPH L. Rus
2.22.2 W. NOTTH 21. Signature of Juneral Service Likensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pryocardial UNKNOWN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be execute signed by the attending physician and be detached for use and the Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnar 3 Ectopic pregnancy Month in the past 12 months 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) □Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 Unknown 1 □ Yes 2 [ZLM6 completely filled in by the funeral director, page 2 should Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 **1**0 1 🗆 Yes 1 ☐ Yes ivision of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saint

Annes

32. Registrar's Signature

Pattani

Sanjay

31. Date filed (Month, Day,

BP9619430

900 South Caton Avenue

2009

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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 5: 25 PM Nov Jefferies ances 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Deat Examiner OSDITO **Funeral** Days Months Director Drid Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mexical Exp. alover must be excitited at 1 Yes 2 □ No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ 3 ₩ Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ge (1-4or 5+) eria es 1 and 2 should be filed w of Health and Mental Hygiel f item 27 Is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) (Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IXOr Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16 21. Signature of Funeral Service Licensee 22. Name and Address of Facility stuneral H Ave, Batto ome, P.A. Md. 21216 Part 1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) **Physician** Days /Medical Due to (or as a consequence of): Examiner Decub Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and burial-tran Due to (or as a consequence of) Physician/Medical the as attending property at a second IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes Division of Vital After this certification funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Afti
completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title o 29c. License number 7 who completed cause of death (Item 23a) (Type, Print) WD 31. Date filed (Month, Day, Year, 32. Registrar's State 10 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TERRI LEIGH JORDAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Colon Burnie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X X Days Hours May 15, 1962 Maryland 217-88-2335 47 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Tes 2 XXVIo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7739 A Woodlawn Avenue 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2XX Married 1 ☐ Yes 2XXNo If Yes, Give be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 2 years Hair Dresser Hair Salon item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Terrance Pollack Peggy Maynard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7739 A Woodlawn Avenue Pasadena, Maryland 21122 Alexander Landsburg / fiance 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) West Arundel Crematory 11/9/2009 Odenton, Maryland 21. Sign of Funeral Se 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, shock, or heart failure. Lis r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-trans and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No be detached for Month Day Year Pregnant at time of death Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: ᇛ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day, Year) NOU-30. Name and address of persol who completed cause of death (Item 23a) (Type, Print) 17

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 11:30 A^M 07, Pritam Singh Janjua November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Director 216-55-8509 64 10-20-1945 India Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modical Examinar must be redified at Director 1 ☐Yes 2 No MD Montgomery Boyds 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 18316 Fable Drive 20841 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 ☐X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: Asian 1 ☐Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician 12 should be filed w h and Mental Hygier ' is marked other th 4 Indian Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Taran Singh ည Harbans Kaur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Sukhwinder Singh / Son 18316 Fable Drive Boyds, Maryland 20841 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 11-12-2009 Odenton, Maryland 21. Signature & Funeral Service Vicens 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A Donaldson Funeral Home & 1411 Annapolis Road Odent

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1411 Annapolis Road Odenton, Maryland 21113 Immediate Cause (Final Physician Cardic Arrythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Staphylococcus Aureus (MRSA) Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examir Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic Renal Cell Cancer attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Acute Renal Failure IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Otner (specify) the 9 Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 icate has been si , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XX No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury death. 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

ithin 24 hours after death.

the Funeral Director: A
ompletely filled in by the fu within 2

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

Records.

Division of Vital

DHMH 17 Rev 1/2001

State

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Fisehatsion Mehari,

RIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0064478

9901 Medical Center Drive Rockville, Maryland 20850

Shady Grove Adventist Hospital

29d. Date signed (Month, Day, Year)

November 07, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NoV. 10 2009 ar 6:33 а м Μ. Kronen Lorraine Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson #4 Dixie Drive If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min 1 □ M 2 🔀 F Mary Land June 23. 1946 63 Director 214-46-1680 Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Baltimore Towson Maryland 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? United States 21204 #4 Dixie Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ☐ Yes 2 🗓 No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Charles Mirabile Venera Morgano and 2 should Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Kronen/Husband #4 Dixie Drive, Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 2 November 11. ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions Examine Due to for as a consequence rany, loading to immedicause. Enter Underlying for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 🔲 No 2**X** No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar

P.O. Box 68760

Division of Vital Records,

DHMH 17 Rev 7/2009

OSLER

DRIVE SUITE 101 TRUSON

hpleted cause of death (Item 23a) (Type, Print)

MD

7 401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 per fn 1898 12/22/09 Repartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Gerard Joseph Kolarik NOV 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Har. BelAin el Ain Healthand Rebabilitation Center 8. Date of Birth 10/31/1916. Birthplace (Month, Day, Year) If Under 1 Year | If Under 24 Hrs State or Foreign **Funeral** Hours Months Davs Min. -03-0982 93 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛛 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 Bonnett Place Unit E 21014 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Optician Optometrist Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony L. Kolarik Elizabeth Kyzour ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor F. Kolarik (Wife) 1400 #E Bonnett Place BelAir MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Most Holy Redeemer 11-09-2009 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Se rvice Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a d be detached for 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 1 ☐ Yes 2 🗖 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊅No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this the funeral 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending 1 □ Yes investigation 2 ∏ No hin 24 hours after death the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) mpletely filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within To the 29b. Signature and the of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

State Registrar 31. Date filed (Month, Day,

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Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene Reg. No. 36020 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year HELEN KRAHLING 11:28 P M NOVEMBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHABILITATION HARFORD FOREST HILL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Age (In yrs. last birthday) Days 1 □ M 200 F Hours Director 87 213-14-0315 Dec. 6, 1921 Maryland Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits is 23a or 28a-f show Parkville Director Baltimore 1 ☐ Yes 2 🔀 💥 🗸 MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with United States 7913 Ardmore Avenue 21234 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 7 is marked other than "natural", or items traumatic event, the "natural Experience to 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes ZXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🔀 🌠 White þ 3√2 Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Hairdresser Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Be John P. Heymann Agnes C. Wagner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: if item 27 is any injury or other trau Barbara L. Cotton-Daughter 3615 Advocate Hill Rd. Jarrettsville MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/09 Baltimore, MD Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) colem /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, physician requires that the death certificate be Physician/Medical attending physi for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) P.O. ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ icate has been s ; page 2 should I Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed The certificate 1 □Yes 2 No After this certification, funeral director, Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) te Hospital or Attending Pl n 24 hours after death. The Funeral Director; After the felletely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7200 132255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Denous I V ZUUS Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2019

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sapeake mber 6. 38 Decedent 10b. County Harford per nnet P1 Divorced	areald give street and number) e Medical Cente S. Sex 1	s. last birthday) Yrs. City, Town or Local Air U.S. 13. \	Be1 If Under 1 Year Months Days Docation 10f. Zip Code 2101 Was Decedent of If Yes, specify Cut 1 Yes, 2 No dent's Usual Occu, kind of work done DO NOT use retire	If Under 24 Hrs. Hours Min. 55 Hispanic Origin? (Soan, Mexican, Puert Specify:	8. Date of Bi (Month, D 12-03-	2009 4c. Cou H rth ay, Year) 1963	Coul	d place (State or Foreign ntry) MD 10d. Inside City Limits 1 Yes No
sapeake mber 6 38 Decedent 10b. County Harford Der mnet P1 d 2 Married Divorced 5. Decedent's vonly highest s stary (0-12) first, Middle, La Lewa1	give street and number) Medical Cente S. Sex 1	S. last birthday) Yrs. City, Town or Local Air U.S. 13. \ 16a. Decection (Give life. Later)	Be1 If Under 1 Year Months Days Docation 10f. Zip Code 2101 Was Decedent of If Yes, specify Cut 1 Yes, 2 No dent's Usual Occu, kind of work done DO NOT use retire	Air If Under 24 Hrs. Hours Min. Min. 5 Hispanic Origin? (Span, Mexican, Puert Specify:	8. Date of Bi (Month, D) 12-03-	4c. Cou H hth ay, Year) 1963	9. Birthy Coun	d place (State or Foreign ntry) MD 10d. Inside City Limits 1 □ Yes X□ No
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c	determin	Certifying Physician: To the best of my k	Certifying Physician: To the best of my knowledge, deat Medical Examiner: On the basis of examination and/or in	Certifying Physician: To the best of my knowledge, death occurred at the the Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated. 29c. License number	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated. 29c. License number 29d. Date sic	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.

36022

Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 7:45 am ^M November 8, 2009 Josephine Lake Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 408 Stemmers Run Road Essex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 🛣 Months Days Hours Min. Director 83 5/29/1926 220-18-7946 Maryland Usual Residence of Decedent 10a. State sa or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Baltimore Essex filed within 72 hours after death with the 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 408 Stemmers Run Road Funeral 21221 A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Davcare Provider Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H Iem 27 Is marked ott Be P Anthony Albert Ehgarten Nina Isabella Newton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 Is
any injury or other trau Leo Marvin Lake (Husband) 408 Stemmers Run Road Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 11/9/ 2009 Bayview Crematory Baltimore, Maryland 21. Stipatur of Funeral Service Lice 22. Name and Address of Facility Bruzdziński Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician as the b attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending thours after death.
-uneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mace Ave Ø 31. Date filed (Month, Day, Year) 32 Registrar's Signature 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician Proposition 1. Decedent's Name (First, Middle, Last) Physician Proposition Proposition

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	Registrar		Cei	rtificate of i	Death		Reg. f	ر ک ک کی	000-		
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	Usual Residence of Decedent										
	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits			
흕	Maryland Frederick			Frede	rick				1 X Yes 2 ☐ No		
Ē	10e. Street and Number	<u> </u>		10f. Zip Code			10g.	Citizen of What Co	untry?		
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era		Was Decedent Ever in	110 110			2 (Chasify Vas	or No	14. Race - Ame			
5	, , , , , , , , , , , , , , , , , , ,	Armed Forces?	10.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Pu	uerto Rican, e	c.)	Black, White			
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ete	15. Decedent's Educatio (Specify only highest grade cor	n mnleted)	16a. Dece	dent's Usual Occup	ation during most of t	warkina	16b.	Kind of Business/	Industry		
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ĕ	12	2	desi	.gner dra:	Etsman		F€	ederal go	vernment		
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, A	liddle, Maid	len Surname)			
	Louis Lancaster				Kat	herine	Tu. Pa	rker			
유	19a. Informant's Name/Relationship (Type. F	Trint)	10h Mailin	Address (Chrost					Zin Codo)		
				ng Address (Street		_			ip Code)		
. 1	Bernadette Lancaster			McLendon				MD 21702			
	20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Remo	20	 Place of Dispo cemetery, crer 	sition (Name of natory or other plac	e)	Date	20c.	Location - City or	Town, State		
	4 □ Donation 5 □ Other (Specify)		t. Pete	r's Cemet	erv 11	/9/2009		ibertytov	vn, MD		
	21. Signature of Fugeral Service Licensee	1/11		2. Name and Addre				neral Hom			
	(affarine ()	Harller	/								
	One Park Control the disease or constitution	0		11802 Lil				rtown, MD			
	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care	use on each line.	eath. Do not ent	er the mode of dylf	ig, such as can	rdiac or respira	tory arrest,		Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition roculting in death)										
	resulting in death) Due to (or as a consequence of):										
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e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of) A	· ·	1	1000C					
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H		540 10 (01 40 4 0011)	equente on.								
n/Medical Examiner	d										
Jec	IF FEMALE:										
2	23h Was decedent pregnant 23c. I	f yes, outcome of pre	gnancy	Tratania nea amana				23d. Date of de	ivery		
Cia	1 TVes 2 TNo	1 □ Live birth 2 □ F 4 □ Pregnant at time	of death 5	☐ Ectopic pregnanc ☐ Other (specify)	у			Month	Day Year		
ıys	9 Unknown	9 🗌 Unknown									
<u>a</u>	Part II. Other significant conditions contribu	uting to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e	Did tobacc	o use contribute to	the cause of death?		
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ble						24a	. Was an autopsy	24b. Were au	topsy findings available completion of cause of		
E							performed'	? death?	2 No		
C	25. Was case referred to medical				26 Place of I	Death (Check		ILI fes	2 LINU		
В	examiner? 1 ☐ Yes 2 No	ital: 1 ☐ Inpatient 2	↑ ED/Outpation	oth	25.			0 DOth - :: 40			
Ĕ	the second secon	8a. Date of Injury	28b. Time of	IL 3 DOX	4 LI Nursin			6 ☐ Other (Spe	city)		
[등	1≱Natural 5 ☐ Pending	(Month, Day, Year) Injury	Worl	ί?	200. Des	CIDE NOW III	ijary occurred			
cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No						
Ę	4 Homicide determined	8e. Place of Injury - A building, etc. (Spe	t home, farm, str ec <i>ify)</i>	eet, factory, office		28f. Loca City	ition (Street or Town, St	and Number or Ru ate)	ural Route Number,		
ē,						O.					
ल	29a. Certifier 1 Certifying Physicia	n: To the best of my	knowledge, deat	h occurred at the ti	ne, date and p	place, and due	to the cause	e(s) and manner a	s stated.		
Medical Certification: To Be Completed by Physicia	(Check only 2 Medical Examiner: one)	On the basis of exam and manner stated.	imation and/or in	vestigation, in my c	pinion, death o	occurred at the	ume, date a	aria piace, and due	to the cause(s)		
Me	29b. Signature and title of certifier			29c. Licens	e number		29d.	Date signed (Mont	h, Day, Year)		
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	· (XIM)	MC	EM	100	,000.	7		1-06-			
	30. Name and address of person who comple			Print)	1	1	V. 1	12170			
	Kothryw rouge CR	Nº 1475	Tane	4 Avenu	ette	deric	K, N	10 2170	02		

State Registrar

/Medic

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at any injury or other traumatic event, the Medical Exeminer must be notified at any once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

09-08579 Stev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Steve G. McNutt,		- For State	Sta	ate of N	Maryla	nd / De	eparti	ment of ficate of	Healtl	n and	Menta	al Hyg	giene		20	009	3602
Physiciar		Registrar 1. Decedent's Name (F	irst, Middle	,Last)			-						. Date of De			3. T	ime of Death
Medical Examin		Steven G	ilbe	rt M	lcNu1	tt, II	[_		Month Novemb				437 hrs
		4a. Facility Name (if no 495 E inner IDE						41	b. City, To Kensir		ocation of I	Death		í	4c. County of E MDNtgDM6		
Funeral		5. Social Security Num		6. Sex		7. Age (In y	yrs. last	birthday)	If Under		If Under 2		8. Date of B	Birth (MI	M/DD/YYYY) (oreign	
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nryland ka-f sh	흜	10e. Street and Number		IL GIRO					10f. Zip	Code	_			10g. C	itizen of What	. Country?	
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Steven Gilbert McNutt Shirley Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street Number, City or Town, Street Number, City or Town, Street Number, City or								State 7in	Code								
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Baltimore, ocmit. Pages I ar Department of Het Important: If ite	t	21. Signature of Funer						22. N	ame and	Address	of Facility	v o	f Mary	/lar	rd Inc		
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		Sequentially list condi	tions.	b			,										
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	dical E			d												-	
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n of ding Ph	Ë	27. Manner of Death 1 Natural			28a. Date	e of Injury b. Day,Year) 2009	- 1	28b. Time of I 1433 hrs	njury :		y at Work?	l (injury occurre fixed Dbje		'D n
Sior Vitend death scior:	cation	2 Accident	5 Pene	ding stigation							es 2		206 Legatio	n / Caro	ot and Numba	r or Pural	Route Number, City
Division or At ours after de leral Direct filled in by	ertifi	Jaiolae		d not be rmined				ne, farm, stree / Highway		, office bu	unaing, etc		or Tow	n. State	9)		e, Kensington, MD
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O	4 Homicide 29a. Certifier (Check only)	ertifying P	hvsician:						time, da	te and plac) and manner		
To the Howithin 24 h To the Fu	Medical			miner:On		of examina									place, and du		ause(s)
E 3 E 8	₩.	29b. Signature and titl	le of certific				-		290	. License					9d. Date signe	,	Day, Year)
		hy	n	٠, ر	N	つ				O.C.N	И.Е.			١	lovember 5), 2009	
7/		30. Name and address		who com				^{23a)} Penn Stree	et Balti	more M	MD 212	_ 					
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Physicia /Medic Examin
Funeral
Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Madical Evaning must be rediffed at ange.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

	1 - State Registrar				Cert	tificat	e of l	Death			Reg. R				
	1. Decedent's Name									2. Date of De		ay	Year	3. Time of Death	
an cal	Ralph	Leon	McGill							Novemb	November 8, 2009 10:45 A.M			М	
ner	4a. Facility Name (If 402 Barb		-	ımber)		4b. City, Town, or Location of Death Laurel							of Death		
	5. Social Security No. 411–78–00		6. Sex 1 Д М 2 ☐ F	7. Age (In yrs. la	nst birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan. 3	th ay, Yea 1	948		place (State or Fore ntry) Nessee	ign
	Usual Residence of	Decedent 10b. County		100 City	, Town or Loc	otion								10d. Inside City Lim	its
ctor	MD State		Arundel		urel	ation								1 □Yes 2 🔀	
Completed by Funeral Director	10e. Street and Num 402 Barb		le Road			10f. Zip	Code 0724					g. Citizen of What Country? nited States			
uner	11. Marital Status 1 ☐ Never Marrie	od 27-Mar	Armed F	edent Ever in U.S orces? 2 No	6. 13. W	Vas Deced Yes, spe	dent of H cify Cuba	lispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.))-		e - Ameri ck, White,	ican Indian, etc.	
by	3 Widowed		l If Yes. G	ive	1	□Yes	2 XNo	Specify	•			Specify	v: Wh:	ite	
eted	(Spec	15. Deceder	it's Education st grade completed		16a. Deced	ent's Usu	al Occup	ation during mos	st of work	ina	16b.	Kind of B	usiness/In	ndustry	
omple	Elementary/Secon	, , ,	1	1-4or 5+)	Masc	OO NOT u	se retired	1)			I	Marbl	e		
To Be C	17. Father's Name (Last)					18. Moth		_{e (First, Middle} ewellir		en Surnan	ne)		
-	19a. Informant's Na		ship <i>(Type. Print)</i> IcGill/Wif	ie	1	~	,			ral Route Numb Laurel				p Code)	
		Cremation	3 ☐ Removal from	State	ace of Dispos emetery, crem	sition (Nai	me of other plac	ce)		Date nber 11	20c.		City or T	own, State	
	4 □ Donation 21. Signature of Fu		 	Hec		_		- 1				_		Home, P.A	
	* ho	40	Cash	/M009	1					St., Bai	_	_		•	
	23a. Part 1. Enter the shock, or hea	he disease, o	r complications that t only one cause on	caused the death	. Do not ente	er the mod	de of dyi	ng, such a	s cardiac	or respiratory	arrest,			Approximate Interval Between	
ı	Immediate Cause ((Final	-a. il	ON SH	THEL		ELL	_ (برور	4 ch	10	25		Onset and Death	
	resulting in death) Due to (or as a consequence of): Sequentially list conditions b.														
Examiner	Sequentially list cor if any, leading to im cause. Enter United Cause (Disease or	rlying a injury	Due to	(or as a consequ	ence of):										
al Exa	that initiated events resulting in death) t	Last	Due to	(or as a consequ	ence of):										
/Medical			d												
Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months? ⊒No	1 ☐ Live	utcome of pregna birth 2 Fetal gnant at time of d	death 3	B						23d. Date of delivery Month Day Year			
	Part II. Other signif		ons contributing to	death but not resu	ilting in the un	nderlying (cause giv	en in Part	I.	23e. Did	tobacc	o use con	tribute to	the cause of death?	,
d b	CHRON	ام ا	IN PIAOC	TIE -	ب لاية	EHIA	+-	CORO	NARL	1 1	Yes	2 □ No	3∏ Pro	obably 4 🗌 Unkno	wn
Completed by	HSTUR	DI	SEVESE,	CH run	ساد ا	005	-Dr	200	JE	24a. Was	s an opsy orm e d	ı	Were aut prior to c death?	topsy findings availa completion of cause	ble of
ပို	25. Was case refer		DINEAN	E , 50	SOVER	3U5	حر			th (Check only		No	1 □ Yes	2 🗆 No	
B	examiner? 1 ☐ Yes 2		Hospital:	Inpatient 2 🗆	ER/Outpatien	t 3 🗆 D	OA Oth	or:	lursing H	\ .		e 6 □Ot	her (Spec	cify)	
ion: T	27. Manner of Deat	h 5 ☐ Pendi		e of Injury onth, Day, Year)	28b. Time of Injury	М	28c. Inju Wor	ry at *k?]Yes 2[7No	28d. Describe	how ir	njury occu	red		
Certification: To	2 Accident 3 Suicide 4 Homicide	6 ☐ Could deterr	not be 28e. Plac	e of Injury - At ho ding, etc. (Specify	me, farm, stre	eet, factor				28f. Location City or To	(Street wn, St	t and Num tate)	ber or Ru	ral Route Number,	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Singature and title of Aertifier 29c. License number 29d. Date signed (Month, Date of Month, Da											stated. to the cause(s)				
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			who completed ca							- 210 -		_1 1	3.57	20770	
ate	Thomas E		Maslen, M	ID /525 (Registrar's Signa	reenwa	ay Ce	enter	Dr	Su1te	e 312 G	ree	npeli	, MD	20//0	
rar		NOV 3	0 2009	Registrar's Signa	p. 19	64.50	Mary .		<u></u> .						

			For State Registrar		State of Ma	arylan		oartment of e <i>rtificate of</i>			lental Hy	giene Reg. No.	009	360	26
	Dhuaisi		1. Decedent's Name (First,	Middle, Las	t)						2. Date of De Month	_	Year	3. Time of	_
+	Physicia /Medic		Elizabeth S								Novembe	< 7,	2009	7:00	Ьм
Ja.	Examin	er	4a. Facility Name (If not ins		1			4b. City, Town,		on of Death			County of De		
40			5. Social Security Number	And Re			last birthda	Je A		ler 24 Hrs.	8. Date of Bir		4750	irthplace (State of	or Foreian
a	Funeral Director		212-20-7180		☐ M 2 [X]F	86	Yrs.	Months Days	Hour	s Min.	09-07-	1923		Country) MD	
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	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ant, the Medical Examinational be notified at	'n		County		10c. Cit	y, Town or							10d. Inside C	
	Ba-f	Director	MD	Harfo	rd		Bel A	_				10- Citi-	en of What C		
	with th		10e. Street and Number 18 N. Brooks	- Dd				10f. Zip Code 21014				USA		ountry?	
	eath	Funeral	11. Marital Status	s Ku	12. Was Decedent I	ver in U.	S. 1:		Hispanic	Origin? (Sp	ecify Yes or No			nerican Indian.	_
(0	fter d r iten insc	Fun	1 Never Married 2	Married	Armed Forces? 1 ∐Yes 2 🖺 N	10		B. Was Decedent of If Yes, specify Cul			Rican, etc.)		Black, Wh		
21215-0036	urs a	by	3 X Widowed 4 ☐ Div	vorced	If Yes, Give Year or Dates:			1 □Yes 2X No	Spec	ify:			Specify: W	hite	
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Maryland	should nd Me mark marti	욘	19a. Informant's Name/Re	lationship (7	ype. Print)		19b. Ma	iling Address (Stree	t and Nui	mber or Rur	al Route Numb	er, City or	Town, State	Zip Code)	
Š	alth a 27 is 27 is ir trau		Joan E. Tin			e)	905	W. Park	Ave	Morga	ntown,	WV 2	6501		
altimore,	of He item		20a. Method of Disposition			20b. P	lace of Dis	position (Name of rematory or other pla	ace)		Date	20c. Loc	cation - City o	or Town, State	
<u>Ĕ</u>	Page ment: If ury o		1 ☐ Burial 2 🗖 Crem 4 ☐ Donation 5 ☐ Of	nation 3 ∐ ther <i>(Specify</i>	Hemoval from State)	,		Crematory		11-0	9-2009	Ba1	timore	, MD	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once.		21. Signature of Funeral S	ervice Licen:	see			22. Name and Add		Scn				me of Be	elAir
	70 = 60 O		men ?		the state of the state of the	41141	- Provide	Inc 610 V					r, MD	21014 Approximat	
			23a. Part 1. Enter the dises shock, or heart failure	ase, or comp e. List only o	one cause on e	the deat	n. Do not e	enter the mode of dy	ring, such	as cardiac	or respiratory a	irrest,		Interval Bei	ween
1	Physicīan /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a	/er	N	4						lyen	n.
	Examiner				Due to (or as	a conseq	uence of):								
	6 -	Jer	Sequentially list conditions if any, leading to immediate	s, e	b. Due to (or as	a conseq	uence of):								
k-	cuted od ransit	Examine	cause. Enter Underlying Cause Usease or injury that initiated events	1	C										
0	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	I Ex	resulting in death) Last		Due to (or as	a conseq	uence of):								
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	eath certific attending p for use as t	/Me	IF FEMALE:		220 If you outcome	of progns	nov								
Вох	atten for us	ian	23b. Was decedent pregnt in the past 12 months	errit	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)				2	3d. Date of d! Month		Year
o	at the de by the tached	Physician/M	1 □ Yes 2 ☑No 9 □ Unknown		9 Unknown	t tille of c	icaiii ;	Other (specify)							
٠ <u>. </u>	res that signed b be deta		Part II. Other significant c	onditions	Intributing to death b	ut not resi	ul inc in the	underlying cause g	ven in Pa	ırt I.	23e. Did t	tobacco us	se contribute	to the cause of	death?
g	w requires been sig should be	ed by	(hvone	00	2 stue tiz.		Vulo	my.	1150	45l	1 🗆 '	Yes 2	□ No 3 □	Probably 4	Unknown
Records,	aw re as bec 2 sho	Completed	Allens	clare	a Ca	Lor	les cc	de V	es e	erce	24a. Was		24b. Were	autopsy findings	available
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Vita	Physician: The lav this certificate has al director, page 2 a	Be C	25. Was case referred to n						26. P	ace of Deat	h (Check only o	-			
<u>></u>	hysic this co	၉	1 Yes 2 No					ient 3 DOA			ome 5 Resi			pecify)	
n O	ling F. After unera	jon:		Pending	28a. Date of Inju (Month, Da		28b. Time Injur	y Wo		- 1	28d. Describe	how injury	occurred		
Sic	ttend death stor:	icat	3 ☐ Suicide 6 ☐	investigation Could not be	28e Place of Init	uru - At bo	me farm	M 1 [street, factory, office	⊒Yes 2		28f Location /	Street and	Number or	Rural Route Nun	nhor
Division of	after after Direction by	Certification:	4 Homicide	determined	building, et	c. (Specif	y)	street, ractory, office			City or To	wn, State)	(Number of I	nuiai noule ivuii	iber,
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; it		29a. Certifier	ertifying Ph	vsician: To the best	of my kno	wledge, de	eath occurred at the	time, date	e and place,	and due to the	e cause(s)	and manner	as stated.	
	he Ho in 24 I he Fu pletel	Medical	(Check only ² 2 ☐ Mone)	edical Exam	Iner: On the basis of and manner sta	f examina ated.	ition and/or	investigation, in my	opinion,	death occur	red at the time,	date end	place, and di	ue to the cause(s)
	To t With To t	Σ	29b. Signature and little of	ertifier		-		29c. Licer	se numb	er	-	294. Date	e signed (Moi	nth, Day, Year)	
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	10		30/ Name and address of p	c/					111	15/	0 1	el se	ے ۔		
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	Sta Registr		NO.	V102	32. Registr	رس	A. ,	barker	,						

ELIZAbeth S. Myers

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TTEM#5perFH, G901,3/19/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29, 2069 October **Physician** 7:31 PM M Margaret E. Mason /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie 12215 Cedarcliff Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 5. Social Security Number 214-52-8231 **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 62 Dec. 18 1946 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, I'm Nedical Examiner must to notified at 1 ☐ Yes 2 ☑ No Director Maryland Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12215 Cedarcliff Drive 21060 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 White 1 ∐Yes 2√∑No Specify Specify: 3 🗆 Widowed 4 🗆 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Household Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Wilson Mason Violet Moody ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is r any Injury or other traur 10370 Hartzsell Road, Midland, NC 28107 Doris M. Linker Date 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 2009 Baltimore, Maryland 21. Signature of Furieral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart influre. List only one cause in each line. Onset and Death Immediate Cause (Final trterioselevo Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 □ No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number eput 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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32. Regis ar's Signature

one

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36028 State of Maryland / Department of Health and Mental Hygien 9 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GEMMA 300M MOLNA Sovambo 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Social Security Number 6 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 214-16-5973 94 Director December 23,1914 Bowdens, NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Director 1 ☐ Yes 2 XNo Maryland Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1403 Vesper Avenue 21222 USA Funeral 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: by Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Housewife Own Home 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Litrenta Mary Ann DeLuca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. 27 Sandy McKoen 7952 Cobbler Lane, Pasadena, Maryland Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 11, 2009 Dundalk, Maryland Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Signature of Funeral Service License 23a. Part 1. Enter the disease, shock, or heart failure. Lis r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, conly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YEA allest hall disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner En sestive Sequentially list conditions, if any, each, immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner a consequence of) The law requires that the death certificate be executed Tiball thial the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 physician attending p use as IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has trector, page 2 s 24a. Was an ospital or Attending Physician: The hours after death.
Ineral Director: After this certificate by filled in by the funeral director, pa 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easte 40 mi

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

09-08414 Deborah Mille

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	J	Certi	ficate of	Death		Re	eg. No. 200	9 3602
Physician	1/	Decedent's Name (First, Middle,Las						Date of Deat Month	Day Year	3. Time of Death 1207 hrs
Medical Examine		Debra Louis		lle		City Town	or Location of	October 3	0, 2009 4c. County of Death	1207 1115
		4a. Facility Name (if not institution, giver 411 Pontiac Avenue	e street and number)		4	Baltimore	or Location of	Death	N/	A
Funeral	7	5. Social Security Number 6. Se	7. Ag	e (In yrs. las	t birthday)	If Under 1 Ye	ear If Under	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Birt	
Director	1	220-66-7263	M 2XF	5	7 Yrs.	Months Da	ays Hours	Min. 06/1	4/1952 Foreig	n untry) _{MD}
	\vdash	Usual Residence of Decedent						0072	1, 2302	
w any		10a. State 10b. County		10c. City, T	own or Location	n				10d. Inside City Limits
0 4	ا ة	Maryland N/A					Baltim			1 X Yes 2 No
Maryl Maryled at c	Director	10e. Street and Number				10f. Zip Code			0g. Citizen of What Cour	
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death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?					n? (Specify Yes or No Puerto Rican, etc.)	White, etc.	can Indian, Black,
r, or i		3 Widowed 4 y Divorced	1 Yes 2	X No	1	Yes 2 X	lo specify:		Specify: Wh	ite
ours al	함	15. Decedent's Education (Specify or	or Dates:	pleted)	16a. Decedent	s Usual Occup	ation (Giva kir	nd of work done	16b. Kind of Business/I	ndustry
6 72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	aunng mo	st of working i	fe. DO NOT us	se retired)	Pharmaceu	tical
5-0036 led within 7 Hygiene.	Ĕ 	7			La	b Tech		Manager (Elizabeth Adalah)	Industr	У
15-00 filed wit al Hygien ed other	Š Re	17. Father's Name (First, Middle, Last) Edsel Pa	lmer					Name (First, Middle, I erie	Sasada	
2121: uld be fil Mental I marked	0	19a. Informant's Name/Relationship (T			19b. Mailing	Address (Str			nber, City or Town, State	, Zip Code)
MD 2121 12 should be fi th and Mental 1.27 is marked umatic event,	1	Debra Moody	(daughter	•)	1426	Isted	Road,	Glen Burni	e, MD 21060	
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 X Burial 2 Cremation 3	Domoval from St		ace of Disposit ematory or oth		cemetery,	Date Nov. 06	20c. Location - City or	Town, State
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	1	23a. Part I. Enter the disease, or comp	Y V	Ab a death F						. 2 2 Approximate Interval
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ial ial	Medical	X UNPENDED	AMENDED 23a			E g897	11/10/	/09 TT		
		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregna		al death	3 Ectopic	pregnancy	23d. Date of delivery Month	/ Day Year
Box 68 death certifi he attending d for use as	Sician	past 12 months?	4 Pregnant at	time of dear	41-	er (Specify)			7	
Bo ne deal the al	EL	1 Yes 2 No 9 V Unknowr	9 OIIKIIOWII	-				100 - Did	obacco use contribute to	the course of death 0
P.O. that the ned by detach	ᆰ	Part II. Other significant conditions	contributing to deat	n but not res	sulting in the ui	ideriying caus	e given in Pan		s 2 No 3 Prol	
ords, I w requires is been sig	<u>g</u>							24a, Was		itopsy findings available
COLC faw re has be	Completed			-				autor perfo	prior to open comped?	completion of cause of
tal Rection: The certificate ector, page		25. Was case referred to medical				26 DI	ac of Dooth /	1 Yes Check only one)	2 No 1 🗸 Ye	es 2 No
/ital Rec	ן מֿ	examiner?	Hospital: 1 Inpatie	ent 2 E	ER/Outpatient		Othor	Nursing Home 5	Residence 6 V Othe	r: Scene
Division of Vital Records, P.O Ital or Attending Physician: The law requires that is after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted in the certificate.	앍	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	iry :	28b. Time of In	jury 28c. li	njury at Work?	28d. Describe	how injury occurred	
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or At or At after d Direct in by	Certification:	3 Suicide 6 Could not	be 28e. Place of Ir	jury - At hor	ne, farm, stree	, factory, offic	e building, etc	. 28f. Location (or Town,	Street and Number or Ru State)	iral Route Number, City
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To the complete complete	Medical	29b ₁ Signature and title of certifier	and manner stated.				ense number		29d Date signed (Mo	
		Marin Amel	1 .00			0.0	C.M.E.		October 31, 200	9
	ŀ	30. Name and address of person who	completed cause of c	leath (Item 2	23a)					
			ssistant Medical	Examine	r 111 Pe	enn Street,	Baltimore,	MD 21201		
Sta Registra	te	31. Date filed (Morro Pay Yell) 20	9 32 Registra	r's Signatur	bar	Les les				
registi	31			-	128					

	Ame	end	negradur	partment of Health and M Certificate of Death	Reg	. No.
	Physici /Medic		Decedent's Name (First, Middle, Last) Shirley Ann Muller		2. Date of Death Month November	Day Yeer 1 2009 10:00 P M
	Examin		4a. Facility Name (If not institution, give street and number) St. Catherine's Nursing Center	4b. City, Town, or Location of Death Emmitsburg		4c. County of Death Frederick
100	Funeral Director		5. Social Security Number 1 9 2 4 9 5 5 5 7 Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country) 1936 Pennsylvania
	death with the Maryland ms 23a or 28a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Maryland Carroll	r Location Keymar		10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	3a or 28a	I Director	10e. Street and Number 750 Crouse Mill Rd.	10f. Zip Code 21757	10g	U.S.A.
920		by Funerat		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto □ Yes 2 X No Specify:	ecfy Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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yland	hould be filed with Mental Hygiene narked other the natte event, Institute	To Be C	17. Father's Name (First, Middle, Last) Theron Thomas Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. M	18. Mother's Name	Stavely	iden Sumame)
Baltimore, Maryland 21215-0036	ages 1 end 2 should be filled i ent of Heelth and Mentai Hygie ht: If Item 27 is marked other i y or other treumatic event, II		Gary L. Muller/ son 1722 20a. Method of Disposition 1 \overline{\mathbb{N}} Burial 2 \overline{\mathbb{C}} Cremation 3 \overline{\mathbb{R}} Removal from State 1722	2 Clearview Rd. Usposition (Name of crematory or other place)	Union Bri	dge, MD 21791 c. Location - City or Town, State 1iddleburg, MD
Baltir	permit. Page Department of Important: If any injury or once		21. Signator of Funeral Service Licensee Larger A	22. Name and Address of Facility Har	ctzler Fu	
% (09.	Physician /Medical Examiner per prijetius and physician an	lical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	home Obstructi	ne lung	Interval Between Onset and Death 72 Mg
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Division of Vital Records, P.O.	To the Mospital or Attending Physician: The law within 24 burs elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	titient 3 DOA Other: 4 Mursing Ho e of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	ce 6 Other (Specify) injury occurred
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	o the Hosp ithin 24 ho the Fund ompletely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d (Check only one) Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and little lof certifier	eath occurred at the time, date and place, or investigation, in my opinion, death occurred. 29c. License number	ed at the time, date	se(s) and manner as stated. e and place, and due to the cause(s) 1. Date signed (Month, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Ty	D 18705	>	11/2109
	Sta	te		Scton Are Emm	vitsburg	Md 21727
DHA	Registr	ar	NOV 1 0 2009 Server B. A	all		

David George Mo:		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	0 00021
David George Mo.		× State of Maryland / Department of Health and Mental Hygiene Certificate of Death	9 36031
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*		Franklin Square Hospital Rosedale Baltimore Co	
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. For	Birthplace (State or eign
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death with the Maryland or items 23a or 28a-f show must be notified at once.	峝	3902 New Section Road 21220 U. S. A. T. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	erican Indian, Black,
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MD d 2 sho d 2 sho lth and n 27 is numati	Ī	Betty Ann Mox (Wife) 3902 New Section Road Middle River, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City	Maryland 2122
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MO Pages sent or		1 11/9/	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pruzdzinski Funeral Home PA	
	-	1 1407 Old Eastern Avenue Essex, Mar	ryland 21221 Approximate Interval
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caminer	ı	Immediate Cause (Final disease or condition resulting in death) a. disease with acute pneumonia and sepsis Due to (or as a consequence of):	Deatti
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Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	ဋီြ	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built of the province of the p	Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated	o the cause(s)
P × V	€	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		November 8, 2	2009
	1	30. Name and address of person who completed cause of death (Item 23a)	
10V		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta Registra	te		
Registr	لك		

			For State Registrar	State of Mary		epartment of F Certificate of I			ne 2009	36032
	Physicia	an.	1. Decedent's Name (First, Middle, La	st)	· ·		2	2. Date of Death Month	Day Year	3. Time of Death
alana.	/Medic		Fannie	Stan	ley			vovember	3 2009	3:48PM
nnie	Examin Funeral Director	er	219-22-3946	al of Balt	yrs. last birtho	Balking Tay) If Under 1 Year Months Days	If Under 24 Hrs. 4 Hours Min.	Date of Birth (Month, Day, Ye	4c. County of Death ar) 9. Birth Cou	place (State or Foreign ntry)
5	and w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	r Location				10d. Inside City Limits
1-1	f shore	o	MD NA	100		ltimore				1√2 Yes 2 □ No
d	the N 28a-	Director	10e. Street and Number		Dal	10f. Zip Code		10g.	Citizen of What Cou	
2	death with the Maryland	i Di	3403 Walbrook	Ave		· ·	216		U.S.A	*
Mora 5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedenl Eventries must be notified it once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 🍇 No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	rify Yes or No- ican, etc.)	14. Race - Amer Black, White, Specify: Mu	etc.
2-0-5	72 hou natura Itaal E	eted	15. Decedent's E (Specify only highest gr	ducation	16a. D	ecedent's Usual Occup	ation	16b	. Kind of Business/Ir	ndustry
25	vithin and the substitution of the substitutio	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done of the contract of the			itu of D	altimore
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Maryland	ld be ental ked o ic eve	To Be	Tilman Stanley	,			Mildred			
ary	shou and M s mar umat	۲	19a. Informant's Name/Relationship	Type. Print)	19b. N	lailing Address (Street			ty or Town, State, Z	p Code)
S Z	and 2		Craig Newton-S	on	290	00 Woodla	nd Ave, 1	Baltimo	re, Md 2	1215
الالم Baltimore,	Pages 1: ment of He ant: If iten ury or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4☐ Donation 5 ☐ Other (Speci	Hemoval from State		isposition (Name of crematory or other place) IS Memoria	i i		Location - City or T	own, State Mđ
se Balt	permit Depart Import any inj once.		21. Signature of Funeral Service Lice	nsee		22. Name and Address March F/	H West			
3	Physician		23a. Part1. Enter nt disease, or com shock, or her rtrailure. List only Immediate Cause (1- nal	one cause on each line.		4300 Waba enter the mode of dyin	ash Ave,		ore Md_	21215 Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cor	nse Heno of)					2 days
	Examiner	L	Sequentially list conditions,	U.	eumo					3 days
	ted 1sit	nine	cause. Enter Underlying Cause (Disease or injury	Due to or as a con	nsequence of		arbic re	nivatel	v Palue	5 days
Wk	ficate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):	nypera		1	1 1000	3 3 73
68760	ate be nysicia ne bur	edical		d						
89	4 _ ()	Med	IF FEMALE:							
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pro 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	y 		23d. Date of deli Month	very Day Year
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ord	w require been sign should b	ted	End Stage	renov a	نع وص	ł ·		1 ☐ Yes	2 No 3 Pro	bably 4 Mnknown
II Rec	hysiclan: The law r his certificate has bu I director, page 2 sh	Completed	Dementia	, Failu	e ·	to Thnu	<u>e</u>	24a. Was an autopsy performed 1 Yes 2	? / death?	opsy findings available ompletion of cause of
Vita	iclan sertific ector,	Be	25. Was case referred to medical examiner?	Lines tol.		lou.	26. Place of Death	(Check only one)		
of	Phys r this ral dir	<u>۲</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpa	atient 3 DOA Other	4 LI Nursing Hom		6 Other (Spec	ify)
on	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Yea	ı <i>r</i>)	ry Work	yat (? Yes 2 □No	3d. Describe how in	njury occurred	
Divisi	after deat after deat Director: d in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	The second residue to the second seco	At home, farm pecify)			3f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying PI (Check only one) 1 Medical Example	nysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, c	leath occurred at the tir or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	with Void to Com	Ž	29b. Signature and title of certifier	0.0:	lan	29c. License			Date signed (Month	
			-tto-the	rendu,	MID	065	5718	No	iember	,3,2009
	3		30. Name and address of person who		(Item 23a) (Ty		0 m = A 1	of B	ALTIM	DRE
	Stat	e	HARITHA PEN 31. Date filed (Month, Day, Year)		ignature 🍙	VAI HO	SPITAL	0+ 0	MLIII	
	Registra	_	NOV 1 0 2009	32. Registrar's S	. par	Kel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
#5 Per FH G897 II / 1990 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar 36033 Reg. No.2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 liam a M /Medical 4a. Facility Name (If not institution, give 4b. City. Town, or Location of Death 4c. County of Death Examiner of chesapeake Anne 1 Future care Arnola 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs. 5.54cm Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** t-20.5638 112 M 2 □ F Months Days Hours Min. Director Siberia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the fredical Examinar must be notified at 1 ☐ Yes 2 XNo Directo Maryland Anne Arundel <u>Severn</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1940 Stone Castle Drive United States 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant Commander United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental F Be ည David Myers Shalinkoff Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 1940 Stone Castle Drive Juanita E. Myers/wife Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park 11/10/2009 ELkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sure of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. wante O homas 1411 Annapolis Road Odenton, Maryland 21113 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.O. | the 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? res 2 No this certificate 1 □Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Latursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation death. 2 Accident 1 Tes 2 No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29c. License number R135 106 12+1 23a) (Type, Print) 27 Tidewater colony Dr. Annapolis, MD 21401 2007 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			giene 🗸 🔾 Reg. No.				
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ith	3. Time of Death			
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white	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	r Location of Death	1	4c. County				
-			Anne Arundel M	edical Cente	r	Ann	napolis		Anne	Arunde1			
	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	n (, Year)	Birthplace (State or Foreign Country)			
н	Director		479-68-6809	ILIM ZAIF	75 Yrs.			05-06-1	934	England			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits			
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	the N	Director	MD Anne 10e. Street and Number	Arundel		Gambril 10f. Zip Code	Is		10g. Citizen of W				
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9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be rediffed at once.	/ Funeral	1 ☐ Never Married 2 🔀 Marr	Armed Forces?		. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ☒ No		Rican, etc.)		k, White, etc.			
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Maryland	ld be ental ked c	To Be	Thomas Patrick					t Gilman		,			
ary	shou nd M mar	-	19a. Informant's Name/Relations	0	19b. Mai	ing Address (Street				State. Zip Code)			
	nd 2 alth a 27 Is		Richard E. Mill	ler / Husban		Callisto							
re,	of He		20a. Method of Disposition			osition (Name of ematory or other place				City or Town, State			
E	Page nent c		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1			15-2009	Crosmessi	ille Maryland			
Baltimore,	permit. Departr Importa any Inju		4 Donation 5 Other (Specify) MD Veterans Cemetery 11-05-2009 Crownsville, Man 21. Signafule of Funeral Service Cicensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A.										
-	89 = 88	J.	YXIIICK	Drugge	10	1411 Ann	apolis Ro	ad Odeni	ton, Mar	ry, P.A. Tyland 21113			
			23a Part 1. Inter the disease, or shock, or heart failure. List	complications that caused	f the death. Do not en					Approximate			
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687	tificate be executed g physician and as the burial-transit	edical		d		(000)	- a 1 10.	,,,		Jaco			
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. Box	death d for	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4 ☐ Pregnant a		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	У						
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s,	The law requires that the death cerate has been signed by the attendinage 2 should be detached for use	Completed by Physician/N	Part II. Other significant condition	ons contributing to death be	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	bacco use contri	bute to the cause of death?			
Records,	w requir s been si should b	ted	Unbetes me	Witus				1 □ Ye	23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
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	ysician: The lis certificate hi director, page	5	Hynertensjor	~				perform	med? → de	eath?			
Vital	ician: The certificate ector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat						
	Physician: r this certific ral director, I		1 ☐ Yes 2 ☐ No		ent 2 ER/Outpatie	nt 3 □ DOA Oth	er: 4 Nursing Ho	ome 5 Reside	ence 6 Othe	r (Specify)			
⊆	Ing Ine	<u>io</u>	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju (Month, Dat	ry 28b. Time (y, Year) Injury	Wor		28d. Describe ho	ow injury occurre	d			
<u> S</u>	Attending or death. ector: After by the funer	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	at ha	unu At homo form of		Yes 2 □No	Opt I postion (O					
2	re Hospital or Attendi 124 hours after death, re Funeral Director: A pletely filled in by the fo	Certification: To	4 ☐ Homicide determi	building, etc	ury - At home, farm, si c. <i>(Specify)</i>	reet, factory, office		City or Town	n, State)	r or Rural Route Number,			
			29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the best	of my knowledge, dea	th occurred at the ti	me, date and place,	and due to the c	ause(s) and mar	nner as stated.			
	To the H within 24 To the Fi complete	Medical	one)	Examiner: On the basis of and manner sta	ited.	nvestigation, in my c	opinion, death occur	red at the time, d	ate and place, a	nd due to the cause(s)			
	Son With	2	29b. Signature and title of certifier	^		29c. Licens		2	9d. Date signed	(Month, Day, Year)			
			· will , m			060	390		11/0	2/2009			
	K		30. Name and address of person			•	(-	Λ					
	Stat	6	31. Date filed (Month, Day, Week)		ARUNDEL ar's Signature	MEDICAL	LENTER	2 HNN	Apouls	MO 21401			
	Registra	٠	MOATASAR	Cenery,	B. Alles			ę					

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar 36035 Certificate of Death Reg. No 7 1 9 1. Decedent's Name (First, Middle, Last) Marco Fidel Neira-Herrera 2. Date of Death Physician/ Month 0603 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9895 Palace Hall Drive Laurel Howard 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min July 21, 1943 Director 218-94-2796 66 Columbia Usual Residence of Decedent 28a-f show 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD Howard Laurel 1 ☐ Yes 2 🔀 🗖 🛚 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9895 Palace Hall Drive 20723 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 XXIo , or Black White etc. 1 Never Married 2 XXMarried þ Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Columbian If Yes, Give "natural", Specify: Completed 3 Widowed 4 Divorced Latino Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12)
Grade 5 College (1-4 or 5+ Owner / Operator Office Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Justiano Neira Felicidad Herrera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marco A. Neira 10107 Madronwood Drive Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Kremation 3 Removal from State cemetery, crematory or other place) West Arundel Crematory 11/13/09 4 Donation 5 Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Earlity Donald Son Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease Approximate Interval Between only one cause on each line shock, or heart failure. Lis Immediate Cause (Final Onset and Death, BLADDER enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: the within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural injurv 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) NOVEMBER 09 ZOUS 2 who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS MO21401 le EFENSE 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Raymond Charles Ott 1136 PM 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Hospital Agnes Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Feb 5, 1 M 2 □ F Months Days Hours Min. 213-60-1921 57 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1703 Summit Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No 1971 If Yes, Give Year or Dates: 1977 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elwood L. Ott Sr. Emma Suter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Vincent, Sister 25860 Dogwood Road Greensboro, Maryland 21639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/09/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor Thomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Onset and Death Immediate Cause (Final tente 30 minutes COVOHERY SUNDAME disease or condition resulting in death) Due to (or as a consequence of): aronary 27 Ten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be

68760 P.O. Box Viťal Records,

that the death certificate be executed Division (

MANMOND Hospital or Attending

completely within 2

attending physician for use as the buria Physician/Medical the ģ signed t ģ Completed been cate has t page 2 sl certificate funeral director, Be Medical Certification: To this After death. 24 hours after death Funeral Director: filled in by

Physician

Examiner

Funeral

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than any Injury or other traumatic event, the Man

-Physician

/Medical

Examiner

burial-tran

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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Examiner

Registrar

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number D0068107 MD

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Villanea Inier

Coton Avenue 900 MU

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one

29a. Certifier

determined

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Cei	rtificate of L	Death		Reg. No.	.009	3603		
Physici		Decedent's Name (First, Middle, Las VIRGINIA MAYNARD 0'[The second secon				2. Date of De.)9 Year	3. Time of Death 2:00A		
Medi Exami		4a. Facility Name (if not institution, give Gilchrist Hospice	street and number)		4b. City, Town, or Towson	Location of Deat	<u></u>	4c. C	ounty of Death			
Funera Director		5. Social Security Number 6. Se 217–26–3417 Usual Residence of Decedent	х Д м 2 XX F 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1927		nplace (State or Foreign Tryland		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County Maryland Baltimore 10e. Street and Number		ty, Town or Lo	cation			10g Citizo	en of What Cou	10d. Inside City Limits 1 ☐ Yes 2XX N		
h with tl ns 23a с nust be	neral	6451 North Charles Str	<u> </u>		21212				JSA	artiry ?		
0036 urs after deaf ural", or iter Il Examiner I	<u>۾</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White, pecify: Whi	, etc.		
Maryland 21215-0036 12 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Homemaker			tion 16b.			Kind of Business Industry Own Home		
Viana ; d be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Maynard Huppman				18. Mother's Nai	me (First, Middle, Brundige	Maiden Sur	rname)			
Mary Mary and 2 shoul fealth and 1 sm 27 is m her traums		19a. Informant's Name/Relationship (Ty) Eugene 0'Dunne	Son	4220 N	ng Address (Street a Orth Charle							
Saltimore, oermit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 XX Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State Fami	emetery, cren I ly Buri	sition (Name of natory or other plac al Grounds	Nov 1		Blue R		mit, Pennsylv		
Departing the polymer of the polymer		21. Sunature of Funeral Service License	Kenakis	22	. Name and Addres	s of Facility Mit York Road	chell-Wied Baltimore	lefeld Mary	Funeral land 212	Home Inc 12		
Physician/ Medical		23a. Part 1. Enter the diserse, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the deatle cause on each line. a. Due to (or as a consequ		er the mode of dying	g, such as cardiad	or respiratory arr	est,		Approximate Interval Between Onset and Death		
Examiner		HURDTENSON										
potential transit	al Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. AORTIC Due to (or as a consequ		315					YEARS		
rificate b ing physicas as the b	Medical	IF FEMALE:	d	_			• • •					
ox o ath cer attendii for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d g ☐ Unknown	ncy Il death 3 🗆 Ieath 5 🗀	Ectopic pregnance Other (specify)	y -		230	d. Date of deliv Month	very Day Year		
requires that the de been signed by the should be detached	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause glv	en in Part I.				he cause of death?		
The law requires attended to be a signerated as been signed page 2 should b	Completed	ATRIAL FIBRILLATION	N				24a. Was a autop perfor 1 Yes	sy med?	24b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available empletion of cause of		
ysician: The ysican: The is certificate director, pag	To Be (25. Was case referred to medical	lospital:	FD/0	Otho	ce of Death (Chec	ck only one)			44		
ending Phy eath. or: After this	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 I	28b. Time of injury	28c. Injury work	at	28d. Describe ho) HUSPICE		
To the Hospital or Attending Phenthing 24 hours after death and 10 the Funeral Director; After the completed filled in by the funeral		3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify))			28f. Location (Si City or Town	n, State)				
he Hosp in 24 ho he Fune pleted fi	Medical	nanner as state d due to the ca id manner as st	use(s) and manner state									
To the with To the com		29b. Signature and title of certifier	000		N 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				igned (Month,	Day, Year)		
12		30. Name and address of person who co	IN, MO 67011	V CHA	rint) RUS ST,							
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure	1					•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 36038 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Perkins Charles Richard 2:00 PM 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 14, 9. Birthplace (State or Foreign Country) 1ST1CT Min. 579-64-2861 1 ☑ M 2 ☐ F Months Days Hours 1949 of Columbia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Elkridge Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6156 Karas Walk USA 21075 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pre Loader UPS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles R. Perkins Sr. Barbara G. Brownell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elkridge, Maryland 21075 Karen W. Perkins, Wife 6156 Karas Walk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/12/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22 Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Cátonsville, Maryland 21228 Momen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adeno carcino ma Due to (or as a consequence of): Renal Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **N**O 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | ₩10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Division of Vital Records, P.O. Box 68760, aftending physician the as for use the detached been signed by should be detach has certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Examiner

Physician

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or any Injury or other traumatic event, the Medical Examiner must be none.

Physician

/ /Medical

Examiner

Baltimore, Maryland 21215-0036

the

Director

Funeral

2

Completed

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/Medical

Physician/Medical Completed Be

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of a fire

Certification: To

Registrar

Medical

State

Shawn EVONS

6 ☐ Could not be

and manner stated.

29c. License number 00063653

Lane,

1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Columbin, Maryland

NOVERSU, 6, 2009

21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedar

5755 31. Date filed (Month, Day, Year)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 [] 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 256 P 11-05-2009 Theodore Frank Paraska /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hart Heritage Street Harford 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F 91 Vrs Director 181-18-0174 PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7410 Cherry Tree Drive 21029 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 TYes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X**☐ No Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "rann plury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer THAPT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Paraska Kathryn Paraska ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen M. Dumer (Daughter) 1433 Banavic Terrace East Bel Air, MD 21015 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4 Donation 5 □Other (Specify) Bayview Crematory 11-11-2009 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rement A **Physician** END STAGR MEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical ASSIS Ed Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 Yes 2 1 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

First Director: After this certificate has been signed by the attending physician and filled in by the functed director, page 2 should be detached for use as the burial-transit

To the Hospital within 24 hours a To the Funeral C completely filled

12

State Registrar

Medical

ALMARA

determined

39889

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

W. MACPHAIL RD Bel AIR 340 21014 SPANUS 615

31. Date filed (Month, Day,

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

32. Registrar's signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Novella (nmn) Plummer November 2009 2:58 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖫 F Months Days Hours Min Director 213-28-0426 Aug. 28, 1930 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryla and Mental Hygiene a tand mental Hygiene are marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked event, it is having a fired must be radified to 1 ∐Yes 2 🔀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Chadford Court Funeral 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 15 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 11 Retail Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Injury or other traumatic John William Thomas Gladys Marcenia Hylton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If Item 27 is any Injury or other trau Peggy A. Stevens / Sister 731 Cherry Hill Rd., Street, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdns. 11-10-09 Bel Air, Maryland rature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracrania nknown /Medical Due to (or as a consequence of): Examiner ypertension MKnown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): physician the burial Physician/Medical attending p for use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) i signed by the a d be detached f o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No of Vital 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 29a Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065421 November, 7, 2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapeake Drive, Bel Air, Maryland 21014 500 Christa Fistler, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

935P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36041 Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death Day Year Physician Jovember 1:00 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N VIEW alt more uvsing tonue Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1 M 2 W Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show traumatic event, the Medical Examinar must be rutified at Director 1 Yes 2 No 1-to more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21213 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 Blac 3 Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Its Manan injury or other traumatic event, Its Manan injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) tomema bmest Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surpame) enni ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rol Kamse Burn Houghton Glen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 09 4 □ Donation 5 □ Other (Specify) ziti mou 21. Signature of Funeral Service Licensis 11213 Ln 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 □ No 2 □ No □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No Certification: To 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

Noverda 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8813

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

ran Evoods Road. MD 21234.

Betty Elizabeth Rosier State of Maryland / Department of Health and Mental Hygiene 2009 36042 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 8, 2009 Medical Examiner 0810 hrs Betty E.. Rosier 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 6 Propeller Drive Middle River **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign WeSt **Funeral** If Under 1 Year If Under 24Hrs. Director Months Days Hours 215-32-0031 country Virginia 77 Nov. 18, 1931 1 M 2 X F Yrs Usual Residence of Decedent iny 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 x No Middle River Marvland Baltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Propeller Drive 21220 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 3 X Widowed Divorced If Yes. Give Year Yes 2 X No specify: Specify: White ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed permit. Pages 1 and ...
Department of Health and Mental Hygone.
Important: If item 27 is marked other than "un
injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Maid Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy F. Shaver Lela W. unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Rosier/Daughter 6 Propeller Drive, Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State November 10, crematory or other place) Burial 2 X Cremation 3 Removal from State 2009Baltimore, Maryland Metro Crematory, Inc. Donation 5 Other Specify 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown a Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate h Yes 2 ✓ Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Division of Vital director, 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient this 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ۵ 1 V Yes No To the Funeral Director: After t completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours a determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of ceptifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 9, 2009 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Manth, Day, Year, Registrar's Signatur

DHMH 17 Rev 1/2001 OCME 2006

State Registra

OCME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 26 per doc 897 11-10-09 State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** November 4, 2009 poation of Death 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ollege If Under 24 Hrs. 8. Date of Birth (Month, Day) 2001 altimore Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 20 F Days Months 244-32-4005 88 Yrs. Director Nov. 3, 1921 North Carolin Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location item 27 Is marked other than "natural", or items 23e or 28e-f show other treumatic event, the Michael Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD orest 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 182 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Specify: white Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry City of New Ellenton Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1821 Selkirk MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: if it eny Injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen (11/6/09 Charlotte, N.C. 4 ☐ Donation 5 ☐ Other (Specify) emetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ral Chapel & Cremation Services 3 Newport Drive Forest Hill, MD 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) 5 days Examiner Due to (or as a consequence of) Examiner use es the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. After this certificate hes been signed by the e funeral director, page 2 should be detached it 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 TYes 2 W No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 🔄 No 1 ☐ Yes Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Special To the Hospital or Attending Phi within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32. Registrer's Signature

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 9,2009 Nancy V. Reynolds 0910 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😾 F Months Days Hours Month, Day, Jan, 19, 217-24-3700 Director 81 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified items 23a or 28a-f Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8830 Walter Blvd 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces or . Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2√☐ No Specify: marked other than "natural", 3 Widowed 4 Divorced Specify: white the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Federal Reserve Bank Registered Nurse or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Reynolds Sarah Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra S.Bogdan-niece Important: If item 27 any injury or other to Huntress Court-Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel
and Cremation Bel Air 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland Nov. 10, 2009 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Parkinsons disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
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1 Yes 2 No Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsy 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 10 1 Tyes Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bluc 31. Date filed (Month, Day, Year) State MOATA Registrar

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5 i	rhis or this or all directions	은	1 ☐ Yes 2 ☑ No 27. Manper of Death	Но	spital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatier		4 LI Nursing Ho		nce 6 Other (Sp	ecify)
5 :	th. Th. After	tion		Pending investigation	(Month, Day,)	(ear) Injury	Work?	at es 2 □ No	28d. Describe ho	w injury occurred	
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5	s afte	Certification:	4 Homicide		building, etc.	Specify)			City or Town	, State)	
	To the response or strending prysician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 (Check only 2	Certifying Physic	cian: To the best of a	my knowledge, deat	h occurred at the time	e, date and place,	and due to the c	ause(s) and manner a ate and place, and du	as stated.
-	the F the F mplet	Medical	Une)		and manner state	d.					
ŀ	S 4 & 5		29b. Signature and title o	Tora M	0		29c. License	number		od. Date signed (Mon	nth, Day, Year)
		-	30. Name and address of	f nerson who ac-	Inleted cause of day	th (Item 20a) (Tim-		13100		101011101	100
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			For State Registrar	S	tate of	Marylan	id / Depa <i>Cer</i>	irtment <i>tificate</i>	of He	ealth a eath	nd Me	ental Hy			9	36046
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	Director		217-20-1852 Usual Residence of Decedent	<u></u>		83	115.					9/7/19	926	<u> M</u>	ary.	land
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ņ	age 1 int of t: If it / or o	-	1 Burial 2 Cremation	3 Remo	oval from Sta	ate c	emetery, crem	atory or oth	er place)	9	Dat 9/11	e		Location - Cit		
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		4 Domation 5 XOther		ILOIIDIII	ent Ga	rdens				2609			erlea,	Mai	ryland
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9 ×	endin r use	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If	yes, outcor	ne of pregnar	ncy I death 3 🔲	Ectonic pre	anancy				1	23d. Date of	deliver	y
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of	Attending Physician: The sr death. setor, After this certificate he tuneral director, page	E.	27. Manner of Death		Ba. Date of it		28b. Time of		. Injury at			. Describe h			оесіту)	
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Division of Vital Records, P.O.	or Att fter de irecte n by t	Certificate: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		le. Place of I building,	Injury - At hor etc. <i>(Specify)</i>	me, farm, stre	et, factory, o	office		28f	Location (S			Rural R	oute Number,
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	To the Hospital or Attendia within 24 hours after death. To the Funeral Director, Al completed filled in by the fu	Medical	29a, Certifier (Check only one) 1 Certifyin 2 Medical Certifyin	Examiner: Or	n the basis o	of examination	and/or investi	gation, in my	opinion, c	death occu	urred at the	e time, date a	and place	e, and due to t	he caus	e(s) and manner stated.
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			SHOAIIS A. I	tA31m	MIMI			MTA	2 V	T fn	n/C	30 6 5	BAL	TIMO	120	MI) 2/201
	Stat Registra	٠ ,	31. Date filed (Month, Day, Year)	2009	Regis	strar's Signat	" Agai	fled								

State of Maryland / Department of Health and Mental Hygiene 36047 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Walter Johnson Raines, Sr. Nov 9, 2009 6:05 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2118 Sunbriar Lane Gywynn Oak **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min 218, 26, 1752 79 Director Sep 6, 1930 Usual Residence of Decedent show 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar onest be nortified at MD Director **Baltimore** Gwynn Oak 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2118 Sunbriar Lane 21207 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces:

1 XYes 2
If Yes, Give Black White etc. 1 Never Married 2 Married 2 ☐ No 951 Baltimore, Maryland 21215-0036 1 □Yes 21 No ≥ Specify: 3 ☐ Widowed 4 ☐ Divorced Ye ar or Dates 1951 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) builder 5 general construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Noah Raines Lula Shifflett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances L. Raines Spouse 2118 Sunbriar Lane Gwynn Oak, MD 21207 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gardens 5 ☐ Other (Specify) Marriottsville, Maryland 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 art 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final **Physician** ence of:

obstructive Pulmonary docume 10 years disease or condition resulting in death) pronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sician and burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown הווכו נווו sertificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide þ Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stahl, Alan MD 4801 Dorsey Hall Drive; ste.201B Ellicott City, MD 21042 31. Date filed (Month Day, Year 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36048 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Barbara 620 AM Rogers November 2 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore
7. Age (In yrs. last birthday) Baltimore C,64 If Under 1 Year | If Under 24 Hrs. | 8. Bate of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months 227-38-216] 78 09 13 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5726 Clover Road 21215 U.S.A. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: Specify: Black 3√ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Nursing Home 6th grade 18. Mother's Name (First, Middle, Maiden Surname) Teresa Field 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5726 Clover Road, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Calverton Vet. 11/10/09 Long Island, NY 22. Name and Address of Facility March F/H West te 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Gastrointestinal Due to (or as a consequence of): Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Domentia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, 2008.

Physician

/Medical

Examiner

Director

by Funeral

MD

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinationates is citified at

the Maryland

ROGER

BARBARA

Maryland 21215-0036

Baltimore,

Examiner attending physician and for use as the burial-transi as nse

To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica

Division of Vital Records, P.O. Box 68760.

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Completed 17. Father's Name (First, Middle, Last) æ Frank Ransom Sr ပ 19a. Informant's Name/Relationship (Type. Print) Shirley Conley-Daughter 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Par 1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed Parkinsons 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 2 TH 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number m.O. 00054482 2,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MC.nley M.D.

32. Registrar's Signature Sinai Hospital Patrick m.O. 31. Date filed (Month, Day, Year) State Darko Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day SUNG **Physician** YON G MOON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONEGOMERLY HOUSE VILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1**⊠** M 2□ F 219-08-1943 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show Injury or other traumatic event, the Modical Examiner must be notified at GAITHERSBURG MONEGOMER 1 Yes 2 No **Funeral Director** MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 17060 KING JAMES WAY 20871 YONTEDMER. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes → ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or i any injury or other traumatic avant 1 ☐ Yes 2X No Specify: ASIAN Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) MANAGEMIENT /Z 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) POUNG HO YOU မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SUNG (50N) 1100 OLD SHIALT KOO JOHNS LN, ELLICOTECITIMD 21042 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition sulting in death) SEPTICEMI Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1105 PICE 1 | Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No To the Funeral Director: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JOCELYIKE KOUAT

J. Kouatchou, mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registfar's Signature

29c. License number

163748

CHOE, 6001 MUNCHESTER MILL Rd, ROCK VILLE, MD, 2085Z

29d. Date signed (Month, Day, Year)

		For State Registrar	State o	f Marylan		rtment of H tificate of I		and Me		giene Reg. No. 20	119	36050	
Physicia	ın.	1. Decedent's Name (First, Mide							2. Date of Dea		Year	3. Time of Death	
/Medic	al	HAZEL		SHECK	eus	4h Oihi Tawa a	a Lacation of		NOTEMBE	29	2009	11:20 A M	
Examin	er	4a. Facility Name (If not instituti 7218 Waldma		ŕ	_ [4b. City, Town, or			t	4c. County of Death Baltimore			
Funeral	9	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	h v. Year)	9. Birthp	lace (State or Foreign	
Director		214-01-7145	1 M 2 X F	92	Yrs.	Wortens Days	liouis	IVIIII.	Sep.	Bal 13,1917	Mar	yland	
land ow		Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	y, Town or Loc	cation						0d. Inside City Limits	
a-f sh	ctor	Maryland Bal	timore	Sp	arrows	Point						1 □Yes 2 X No	
iff the	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Coun	try?	
s 23a nust b	eral	7218 Waldman	т	edent Ever in U	6 12 14	2121		ain? (Spec	aifu Von or No	United	State		
	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	Armed Fo	rces? 2 ∑X No ∕e		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 X No	an, Mexicar Specify:	giii / (Spec 1, Puerto F	Rican, etc.)	Bla	ck, White,	etc.	
2 hou latura ical E	ted	15. Decede	nt's Education	41001	16a. Deced	ent's Usual Occup	ation	a _ #		16b. Kind of B	usiness/Inc	dustry	
ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12)	est grade completed) College (1	I-4or 5+)		kind of work done o	during mos i)	t of workin	g	Litho	oronh	77	
iled w Hygier ther th	ပ္ပြဲ	17. Father's Name (First, Middle	l act)		Mana	gement	18 Motha	r'e Name	/Eiret Middle	Maiden Surnar		<u>у</u>	
d be f ental F ced of	To Be		erfield					herin			ne)		
shou and M s mar	-	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailing	g Address (Street	and Numbe	er or Rural	Route Numbe	er, City or Town	, State, Zip	Code)	
and 2 ealth i		Diane Hilder/	Niece									land 21219	
Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 4 ☐ Donation 5 ☐ Other (State	cemetery, crem	sition (Name of natory or other plac natory, Ir		Tovemb 2009	per 10,	20c. Location		wn, State aryland	
permit. Departmine importal any lnju		21. Signature of Funeral Service			ton 22.	Name and Addres	ss of Facilit	y Cre	nation	Society	of N	Maryland. In	
T-125	-	23a, Part1. Enter the disease,	or complications that c	aused the deat		99 Freder					aryıa	Approximate Interval Between	
Physician	1	shock, or heart failure. Li Immediate Cause (Final										Onset and Death	
/Medical		disease or condition resulting in death)	a. Due to	or as a conseq	uence of):							6 MONTHS	
Examiner		Sequentially list conditions,	b. PARK	4N501		DISEASE	E					3 YEARS	
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseq	uence of):								
execu n and ial-tra	Exar	that initiated events resulting in death) Last	CDue to	or as a conseq	uence of):			-					
ficate be executed physician and s the burial-transit	edical		d										
		IF FEMALE:	00.11										
The law requires that the death certifi te has been signed by the attending I age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come pf pregna pirth 2 Feta ant at time of d	al death 3□	Ectopic pregnancy Other (specify)	′				ate of delive onth	ery Day Year	
at the de by the a tached	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unkn										
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requir een si nould I	ted	HYPERTENSION) PERLIPHE	rete VI	ISCULA	r diseas	se,		1 D Y	es 2 No	3 ☐ Prob	ably 4 Unknown	
ie law has b je 2 sl	Completed	STROKE							24a. Was a autop perfor	sv	Were autoprior to condeath?	psy findings available mpletion of cause of	
		25. Was case referred to medic	al				OC Plans	- (D 4)-	1□ Yes	2 X No		2□ No	
Physician: this certific al director,	To Be	examiner? 1 Yes 2 No	Hospital:	npatient 2	ER/Outpatient	3 DOA Othe	or:		(Check only on ne 5 ⊠ Resid	lence 6 □Oth	ner (Specifi	v)	
ding Ph J. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pend	28a. Date	of Injury th, Day Year)	28b. Time of Injury	28c. Injun Work				ow injury occur			
or Attending Physician: after death. Director: After this certifica in by the funeral director, i	cat	2 ☐ Accident inves	tigation	of injury - At h	ome farm etre	M 1 □	Yes 2□I		Pf Logation /S	Stroot and Numi	har or Pura	I Route Number,	
afor A after i Direction by	Certification:	4 ☐ Homicide deter	mined 200. Place buildi	ng, etc. (Specif	y)	et, lactory, office		20	City or Tow		oer or nura	r noute Nurriber,	
	Medical C	29a. Certifier 1 Certify (Check only one) 1 Medica	ing Physician: To the	best of my kno asis of examina ner stated.	wledge, death ation and/or inv	occurred at the tir	ne, date an pinion, dea	nd place, a ath occurre	nd due to the o	cause(s) and m	anner as st	ated. the cause(s)	
To the within To the Comple	ĕ E	29b. Signature and title of certif		ner stated.		29c. License	e number		- 2	29d. Date signe	ed (Month,	Day, Year)	
		James	Lunder	MI		D620	37		1	VOVEMA	300	9 2009	
31		30. Name and address of perso	1			Print)				40 FOINI			
Stat		JENNIFER HAY 31. Date filed (Month, Day, Yea	ASH.L 550	5 HOP egiz rar's Signa	KINS B	AYVIEW	CIRC	LE	BALTI	MORE, M	D_21	224	
Registra		NOV 1 0 2009	Benene)	p. 4									

_			For State Registrar		State o	of Maryl		artment of F		and Mental H	ygiene Reg. No	2009	3605	5 I
	Physici		1. Decedent's Name Phyllis							2. Date of Month Novemb	Day		3. Time of De 10:40A	ath M
	/Medio Examin		4a. Facility Name (If Masonic	-	ive street and nu	m <i>ber)</i>			ysvi1	of Death 1e		County of Deat	h	
	Funeral Director		5. Social Security Nu 219-05-015	5.5	Sex 1☐M 2☐XF	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Day, Year)	9. Birti Co 9 Balt	nplace (State or Fo untry) O •	oreign
	inyland		Usual Residence of I 10a. State	10b. County		10c	. City, Town or Lo						10d. Inside City L	
	the Ma	ecto	Md .	Balt	0.		Perry	Hall 10f. Zip Code			10g Cit	tizen of What Co	1 ☐ Yes 2[ZNo
	th with 23a or	alDi	5511 Dunr		ne				128		, og. o	USA	unity.	
936	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, if a Medical Evariner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 🛣 Widowed	_	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	orces? 2 TNNo ve		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origan, Mexican Specify:	gin? (Specify Yes or i, Puerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: Wh	e, etc.	
5-0	natura	eted	(Specif	15. Decedent's I fy only highest g	 Education rade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most	t of working	16b. K	ind of Business/	ndustry	
2121	yiene. r than	Be Completed	Elementary/Secon 12th	dary (0-12)	College (1-4or 5+)	Cler:		d)		Reta	ail Sale	s	
pu	be filed tal Hyg rd othe event,		17. Father's Name (F	First, Middle, Las	et)					r's Name (First, Midd	lle, Maiden	Sumame)		
ıryla	should od Men marke matic	2	William I 19a. Informant's Nar				19b Mailir	ng Address (Street		y Lathem or or Rural Route Nun	ther City o	or Town State 7	in Code)	
, Ma	and 2 s saith ar n 27 is ier trau		Robert Kr		(1),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Son				ane Perry				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evone.		20a. Method of Dispo 1 ☐ Burial 2 2 4 ☐ Donation	Cremation 3	□Removal from	State 20	b. Place of Dispo cemetery, cree Bayview	sition (Name of natory or other plac	(a) 1	Date 1-10-2009		ocation - City or to . Md .	Town, State	
3alti	permit. Departm Departm Importar any inju		21. Signature of Fun				22	. Name and Addre				uneral H		
	707 # Ø		23a. Part1. Enter the	e disease, or cor	mplications that of	caused the c	death. Do not ent			d. Nottin	_	, Md. 21	Approximate	
wb.	Physician /Medical Examiner pruisican and pruisi-transit	Examiner	shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list con- if any, leading to imm cause. Enter Under Cause (Disease or in that initiated events resulting in death) La	ditions, nediate lying njury	b. AS no Due to	(or as a con	esequence of): OPD Sissequence of):	Decomps afent)	Denti	tun s Actelia	ris		Interval Betwee Onset and Dea	
68760	tificate bug physic as the bu	ledical			d									
Division of Vital Records, P.O. Box 6	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	nonths?		oirth 2 ☐ F nant at time	Fetal death 3	Ectopic pregnancy Other (specify)			-	23d. Date of deli Month	very Day Year	r
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Vit.	/siciar s certif directo	To Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐ X		Hospital:	Innatient :	2 ER/Outpatien	t 3□ DDA Dth		of Death (Check only rsing Home 5 Re		6 □Other (Spec	i6.)	
l of	ng Phy fter thi		27. Manner of Death	5 Pending		of Injury th, Day Yea		28c. Injun Worl		28d. Describ			<i>"y)</i>	
Division	or Attendii after death. Director: Al in by the fu	ertification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not determined	be 28e. Place		At home, farm, str	M 1 🗆	Yes 2 ☐ ħ	28f. Location	(Street an own, State	nd Number or Ru	ral Route Number,	
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical C	29a. Certifier .1. (Check only one)	Certifying P	miner: On the b	best of my asis of exam ner stated.	knowledge, death nination and/or in	occurred at the time time of the time of time of the time of time of time of the time of t	ne, date and pinion, deat	d place, and due to the h occurred at the time	e cause(s) e, date and) and manner as d place, and due	stated. to the cause(s)	
	To the To the comp	ž	29b. Signature and ti	itle of certifier	P			29c. License			29d. Dat	te signed (Month	, Day, Year)	
	3	-	30. Name and address	ss of person who	completed cause	M)	Item 23a) (Type		2146			11-9-09	,	
	~		ROBERT	LIBER	rTo, W	10.3	10 8 R	and ST	- Be	elto, my	15	1224		
	Sta Registr		31. Date filed (Month	, Day, Year)	09 25	egistrar's Si	ignature ba	Rod				7		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36052 1 - For State Registrar Reg. No 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11-04-2009 **Physician** Kenneth A. Shannon 0225 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-29-1948 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days 1 X M 2 □ F 61 MD Director 218-52-4927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 USA 2115 White House Rd Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No 1 ☐ Yes 2 📉 No ò Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Charles Shannon Elva Eberwine ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda C. Shannon 2115 White House Rd Bel Air, MD 21015 (Wife) permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 11-05-2009 Bayview Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Arvice Licensee 7. Jan Inc 610 W.MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ore HOUL Physician ocavala disease or condition resulting in death) /Medical consequence of): Due to (or as **Examiner** Ovonav Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 Tyes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 K ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of co 30. Name and address Ave. Bel Air, mp KevinSnud

Registrar

31. Date filed (Month, Day,

Year

			1 - For State Registrar	State	of Maryl	and / Depa		nt of F <i>te of i</i>			-	_	2009	36053	3
			Decedent's Name (First, Middle, La	nst)							2. Date of Dea	ath		3. Time of Death	_
	Physicia		Leona Stonesife	r							novemb	er 6		10:10 a ^M	
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and n	umber)		4b. City	, Town, o	r Location	of Death		4c. County of Death			
42. ⁷⁷			3 Mohawk Avenue				1	Glen					Anne A		
	Funeral			Sex 1 □ M 2 🕱 F		yrs. last birthday)	If Unde Months	er 1 Year Days	If Unde Hours		8. Date of Birt (Month, Da	h y, Year)	Co	thplace (State or Foreign ountry)	
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	land ow		10a. State 10b. County		100	. City, Town or Lo	cation							10d. Inside City Limits	_
	Mary If sh	tor	MD Anne An	rundel		C	len	Burn	ie					1 ∐Yes 2 ∑ No	
	or 28g	Director	10e. Street and Number		1		10f. Z	ip Code			T	10g. Citi	zen of What Co	ountry?	_
	th wit		3 Mohawk Avenue					2	21061			Un	ited St	ates	
	r dea	Funeral	11. Marital Status	Armed F		in U.S. 13.	Was Dec	edent of Hecify Cuba	lispanic C an, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)		 Race - Ame Black, White 		
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altimore,	permit. Pag Department Important: any Injury once.	W	4 ☐ Bonation 5 ☐ Other (Spec 21 Signature of Funeral Service Doe					and Addre			·		ral Hom		
B	permit. Pages 1 Department of H Important: If Ite any Injury or ott	2	K L CX	1		4	107	Wilke	ens A	lvenue	e, Balt	imor	e, Mary	land 21229	
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that	caused the	death. Do not en	ter the mo	ode of dyir	ng, such a	as cardiac	or respiratory a	rrest,		Approximate Interval Between	
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	tificat ig phy as the	ledic		u		-									
Box	death certific e attending p d for use as	N/NE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pr		Tectonic	pregnano	ev.			N	23d. Date of de	-	
	ed for	Physician/Me	in the past 12 months? 1 □Yes 2 No		gnant at time		Other (,				Month	Day Year	
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5	Physician: r this certific ral director,	o Be	examiner?	Hospital:	7 Innatient	2 ER/Outpatie	nt 3□[OCA Oth	or.	Nursing Ho	h (Check only o		6 ☐ Other (Spe	acify)	_
0	g Phy ter thi	n: To	27. Manner of Death		e of Injury onth, Day, Yea			28c. Injui Wor		- I	28d. Describe			, only,	_
0	endin ath. or: Af	atio	Natural 5 Pending investigation	on	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	М		Yes 2	□No					
Division of	or Atter de Irecto	Certification:	3 ☐ Suicide 6 ☐ Could not determined	28e. Plac	ce of Injury ding, etc. (S)	At home, farm, str pecify)	reet, facto	ry, office			28f. Location (City or To	Street an vn, State	nd Number or R	ural Route Number,	
	oltal c		200 Cadifica	busisias. To A									\	a state d	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical	29a. Certifier (Check only one) Certifying F 2 Medical Example	milner: Øn the	basis of exa	/ knowledge, deat mination and/or in	rvestigation	on, in my	opinion, d	eath occur	red at the time,	date and	d place, and du	e to the cause(s)	
	To the vithin somple	Me	29b. Signature and title of cert/lier				2	9c. Licens	e numbe	r		29d. Da	te signed (Mon	th, Day, Year)	_
	0		1 Setten	ug h	ND				185	587		NO	V 6	2009	
	5		30. Name and address of person and	completed ca	use of death	(Item 23a) (Type,	Print	/			Soth		11	2,220	_
			PAUL CAC	RMC	54	700	(a	ton	AVE	2/	SOHZ	W	11	464	
	Sta Registr		31. Date filed (Month, Day, Year)	Beneva	Registrar's S	orgnature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36054 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JOVE mber Anna Szlovak 8-00 pm 2000 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Ctr. 5 Q 2 Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours 218-36-8089 86 Hungary Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 Lansing Road 21060 Hungary Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Cashier</u> Retail Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrasne Szlovak Anna Malva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Billings/Son 2056 Shore Drive, Edgewater, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Cremation Services 11/09/2009 20a. Method of Disposition 1 Durial 2 X Cremation 3 Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

iral", or items 23a or 28a-f shov Examiner must be notified at

"natural",

other traumatic event, the Medical

permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men

Maryland 21215-0036

Baltimore,

resulting in death) attending physician and for use as the buriaf-transit

Examine Physician/Medical IF FEMALE: Completed by Be 25. Was case referred to medica ပ္ 27. Manner of Death Certificate:

Medical

9 Unknown

examiner?

1 Natural

3 Suicide 4 Homicide

29a, Certifier

Accident

2 No

signed by the a d be detached f

has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I

Records, The law requires

Division of Vital

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

Pregnant at time of death 5 Other (specify)

Ectopic pregnancy

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 X No 24a. Was an autopsy

3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 📆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifier

5 Pending

Investigation

ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

31. Date filed (Month, Day, Year, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Gerard Charles Sauer

2009 36055

		Registrar Certificate	or Death	Reg. No.								
Physicia Medical Exami	in/	1. Decedent's Name (First, Middle,Last) 2. Date or Death Month Day Year 13.1 brs										
		4a. Facility Name (if not institution, give street and number) 104 Doncaster Road	4b. City, Town, or Location of Joppa	Death 4c. County of Death Harford								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under Months Days Hours	Foreign								
Director		215-48-9724 1 M 2 XF 61	Yrs.	11/28/1947 Country (unknown)								
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location	10d. Inside City Limits								
8 .:	ă	Maryland Harford Joppatow		1 Yes 2 X No								
e Maryl or 28a-f	<u>ا</u> ت	10e. Street and Number 104 Doncaster Road	10f. Zip Code 21085	10g. Citizen of What Country? USA								
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	- 1		3. Was Decedent of Hispanic Origin	n? (Specify Yes or No- 14. Race - American Indian, Black,								
death or item must b	Funeral	1 Never Married 2 X Married Armed Forces? 1 X Yes 2 No	If Yes, specify Cuban, Mexican, F	Title i de e								
	ক্র	15 Decedent's Education (Specify only highest grade completed) 16a, Dec	1 Yes 2 X No specify:	ind of work done 16b. Kind of Business/Industry								
	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	ing most of working life. DO NOT u									
5-0036 led within 72 hours afte lygiene. other than "natural", the Medical Examiner	ompleted	17. Father's Name (First, Middle, Last)	istant Sales Man	Name (First, Middle, Maiden Surname)								
	()	Edward Walter Sauer	l l	ces Catherine Frank								
MD 2121 2 should be fi th and Mental 27 is marked umatic event,				per or Rural Route Number, City or Town, State, Zip Code) 1, Joppatowne, MD 21085								
ore, MD set 1 and 2 sho of Health and If them 27 is her traumatin		20a. Method of Disposition 20b. Place of D	Disposition (Name of cemetery,	Date 20c. Location - City or Town, State								
S = S		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	-	11/9/09 Towson, Maryland								
Baltimo permit. Page Department o Important: injury or oth	i	21 Signature of Funeral Service Licensee	22. Name and Address of Facility	McComas Funeral Home, P.A.								
Physician	-	23a. P. nt I. Ent the disease, or complications that caused the death. Do not e	1317 Cokesbury anter the mode of dying, such as cal	Road Abindon Mary and 21019 urdiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and								
/Medical xaminer		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular		Death								
AGIIII O		or condition resulting in death) Due to (or as a consequence of):										
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		- 08								
108 - #	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
executed in and il - transit		d. UNPENDED AMENDED										
18760, tificate be exenge physician as the burial -	n/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery								
687 certifica nding p		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5		pregnancy Month Day Year								
Box 6	Physicia	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)									
P,O. I that the ned by the detache	by Pt	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Par	nt I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 No 3 Probably 4 Unknown								
ords, P.C. w requires that sheen signed should be deta	ted			24a. Was an 24b. Were autopsy findings available								
corce law re e has be	Completed by			autopsy performed? prior to completion of cause of death? 1 Yes 2 ✔ No 1 Yes 2 No								
Vital Rec ysician: The l his certificate director, page		25. Was case referred to medical	26.Place of Death (
Vita hysicia this ca	To Be	1 Yes 2 No		Nursing Home 5 Residence 6 ✔ Other: Scene ? 28d. Describe how injury occurred								
Division of Vital Records, P.O. all or Attending Physician: The law requires that the safer death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	ne of Injury 28c. Injury at Work'									
Divisior pital or Attenct ours after death erral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farr	n, street, factory, office building, etc	c. 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Div spital o nours af neral D	Certi	4 Homicide determined (Specify)										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.	n occurred at the time, date and pla restigation, in my opinion, death occ	curred at the time, date and place, and due to the cause(s)								
7. × 1.00	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
. .		(Icle) Saller Seed +	O.C.M.E.	November 6, 2009								
1041		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner	111 Penn Street, Baltimore	e, MD 21201								
	tate	31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature	bases									
Regis	ucli	THUY - LAND LEWIS G.	77									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #12, per Fh 9897 11.17.09 TT State of Maryland / Department of Health and Mental Hygiene 36056 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Steedman A^M November 6 2009 9:10 Medical Barbara 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Timonium Stella Maris Hospice Baltimore Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ☐ M 2 💢 F Months Davs Hours Min **Director** 219-12-4178 Maryland 1924 85 13 Jan. Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Forest Hill 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 106C Gwen Drive 21050 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3 Midowed 4 □ Divorced Specify: Completed Year or Dates. 1944-1946 White any injury or other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mail Carrier U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bergen Thomas Brown Margaret Akehurst Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Moore / Daughter 239 Old Mill Road, Conowingo, Maryland 21918 20a. Method of Disposition
1 □ Burial 2 □ Fermation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other placel 4 Donation 5 Other (Specify) Hilltop Service Corp. 11-11-09 Towson, Maryland nature of Fundral Service Licensee 21 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the a d be detached f Yes 2 No 1 L Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 **X** N certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Barbara Steedman Division

a.m.

9:10

2009

Nôvember 6,

State Registrar

9

29a. Certifier (Check only one)

29b. Signature and

JACKIE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JONES,

2300 DULANEY VALLEY RD.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

29c. License number

X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygien 1-For State Certificate of Death	Reg. No. 200	9 3605
1 1. Decedent's Name (First, Middle,Last) 2. Date	of Death	3. Time of Death 1930 hrs
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		
2618 West Cold Spring Lane Baltimore	to of Right on (CDD 2000) (1. Bit	Athologo (State or
214-64-5493 tank 1 M 2XF 48 Yrs. Months Days Hours Min. March 1 M 2XF 48	Foreig	
10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 No
10e. Street and Number 10f. Zip Code 2842 Boarman Ave. 2/2/5	US	A
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, 6		ican Indian, Black,
	Specify: R	ack_
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work don during most of working life. DO NOT use retired)	ne 16b. Kind of Business/	Industry
Homemaker	Dome	stic
	Widdle, Maiden Surname)	
Daniel ricory	oute Number, City or Town, State	e, Zip Code)
Mrs. Eunice Kush 14933 Edgemere F	tve. Balto.	<u>Md</u>
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Removal from State rematory or other place)	20c. Location - City or	Town, State
4 Donation 5 Other Specify: 1112	Dunda	IK, MA.
Vayssey Fray Joseph L. Russ Fun	eral Home, t	21216 21216
failure. List only one cause on each line.	atory arrest, shock, or heart	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Intracerebral hemorrhage Due to (or as a consequence of):		Death
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
X LINPENDED X AMENDED 45 FU 220 27 DOTME 0808 1	2/18/00 TT	
IF FEMALE: 23c. If yes, outcome of pregnancy		<u></u>
23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Month	Day Year
1 Yes 2 No 9 V Unknown g Unknown		
à 1		
24		utopsy findings available completion of cause of
11.	performed? death?	
25. Was case referred to medical examiner?		
O 1 Yes 2 No 1 Inpatient 2 ENOutpatient 3 DOA 4 Norsing nome		r: Scene
1 X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Lo or		ural Route Number, City
	the cause(s) and manner as sta	led.
(Check only 1 Certifying Physician: To the cest of my knowledge, death occurred at the time, date and place, and due to	ne, date and place, and due to the	ne cause(s)
(neck only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.		
one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the ting and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Mo	•
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)	29d. Date signed (Mo	
se Completed by Physician/Medical Examiner	Decedent Name (First, Middle, Last) Scalar Security Number Collage Security Number Collage Security Number Collage Colla	2. Descent's Name (First, Models, Last) 2. Descent of Death Moorth Day, 2009 Year November 3, 2009 Year November 1, 2009 Year No

OCME

State of Maryland / Department of Health and Mental Hygiene For State Registrar 36058 Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 6, 2009 7:15 am^M ROBERT HUNTLY SOUDER November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Brighton Columbia Gardens Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 5, 19 7. Age (In vrs. last birthday) 5. Social Security Number Days **Funeral** Hours 1**X**XM 2□ F Months 85 1924 Maryland 217-12-9453 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination must be notified at M∑Yes 2 No Director MD Carroll Woodbine 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21797 7225 Patton Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: 1 ☐ Yes 2√☐ No Specify White Baltimore, Maryland 21215-0036 þ 3X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Heating Sheet Metal Mechanic H & C Ø 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Coon Souder Lois Elsworth Amos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 21797 Roberta J. Shaffer/Daughter 7225 Patton Drive, Woodbine, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Emmanuel Cemetery 11/9/2009 Scaggsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Avenue, M01103 Laurel. 23a. Part I. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. Alzheimer's Disease Physician 3 years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Physician/Medical attending pl IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) □Yes 2□No signed by the a Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 24 No 3 Probably 4 Unknown 1 □ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy perform page 2 No 1 ☐ Yes 2 🛣 No certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Assisted Other: $4 \square$ Nursing Home $5 \square$ Residence $6 X \square$ Other (Specify) Living 1 ☐ Yes 2 💆 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Anatural 28b. Time of 28a. Date of Injury (Month, Day, Year) Certification: After 1 Injury To the Hospital or Attending 5 ☐ Pending investigation in 24 hours after deam.
The Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD. November 6, 2009 D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Snowden River Parkway, #301 Columbia, MD 21045 8600 Harry Li, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Department of Health and Mental Hygiene 09-08591 Joseph L. Taylor 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 4, 2009 2147 hrs Medical Examiner or 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Baltimore** University Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** Foreign Months Hours Min Davs Director Country) 212-98-8959 M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Yes 2 No IA 28a-f show Itimor must be notified at once, hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 2121 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 1 Yes 2 No specify: Specify Widowed 4 Divorced If Yes, Give Year à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) es 1 and 2 should be filed within 72 l of Health and Mental Hygiene. lant: If item 27 is marked other than or other traumatic event, he Medical Baltimore, MD 21215-0036 Unemployed 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be seph la reen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mothe 703 New Towne Itnna potis MI enise 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition rematory or other place) Burial 2 Cremation Pages 1 altimore tment c Important: Mation 5 Other Beecify 22. Name and Address of Facility nature of Funeral Se ice Licensee Approximate Interva 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as findiac or resultatory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Gunshot Wounds (2) of Head and Left Arm Immediate Cause (Final disease `xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed peen 24a. Was an 24h. Were autonsy findings available prior to completion of cause of autopsy certificate has death? performed? 1 V Yes 2 No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other, Hospital: 1 Inpatient Other ER/Outpatient 3 Nursing Home 5 Residence 6 2 this ٩ 1 ✓ Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Nov 3, 2009 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760, After To the l 2

Funeral Director; stely filled in by the

1 Natural 2

Pending Accident Investigation Could not be Suicide determined 4 V Homicide 29a. Certifier 1

(Specify) In Car on Local Street Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Yes 2 V No 28e. Place of Injury - At home, farm, street, factory, office building, etc.

1800 hrs

O.C.M.E.

Subject shot

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1300 block of W. Fayette Street, Baltimore, MD

November 7, 2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of rerson who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Driving 17 See 17 00 **OCME 2006**

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36060 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2:40 AM **Physician** 1A410R 2009 Ames /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 324 West LASAgelte Street 13 AZTO. 21217 BAUTIMUR mo If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 217-46-6298 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, it a Medical Examinat must be notified at 1 Nes 2 No Director altimole 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA atavette 2121 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Not If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) blic Baltimore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Place Wingfield Fredrick 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutue 21. Signatur Funeral Service Lensee 22. Name and Address of Facility Furera DW MD 212 Heights 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 30 year **Physician** Due to (or as a consequence of): /Medical **Examiner** rumbry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be execute burial-tran Division of Vital Records, P.O. Box 68760, inhetes Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HERATIOS perform 2 🗆 No Immreo de 1 ☐Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Printing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s). 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) 2009 DIZUID Hill Bre, BDISTIME, MT, MD

N25373

moreland

November 09, 2009

9-08641		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Le	gible.	
ames Thompson		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death	2009	3606
Physician		Registrar 1. Oecedent's Name (First, Middle,Last) 2. Oate of Dea	th 3.	Time of Oeath
Medical Examin	er	Odities Hjoripse.		1829 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Oeath Northwest Hospital Randallstown	4c. County of Oeath Baltimore Count	v
Funeral	٩		rth (MM/DD/YYYY 9. Birthp	
Director	- 1	216-50-0619 1 M 2 F LOD Yrs. Months Days Hours Min. July	2 1949 Ma	ry)
	-	Usual Residence of Decedent /	4, 11111100	14700710=
w any		10a. State 10b. County 10c. City, Town or Location		Od. Inside City Limits Ves 2 No
Maryland 28a-f show	흸	MD Baltimae Baltimae	log. Citizen of What Country	n
death with the Maryland or items 23a or 28a-f shoust be notified at once.	Director	3134 Cambridge Dr 21244	USA	
ms 23s	曺	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 1) (Sp	o- 14. Race - America White, etc.	n Indian, Black,
r death	Funeral	Never Married 2 No 1 No	71	acle
urs afte	<u>`</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done	Specify: 5 10	ustry
72 hount nat al Exa	뺭	during most of working life. DO NOT use retired)	1	,
5-0036 led within 72 hours al tygient than "natural tother than "natural tothe Medical Examin	Completed	12 Customer Service	Utilit	4
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than event, the Medica	Be C	17. Father's Name (First, Middle, Last) Earl Frank Thompson 18. Mother's Name (First, Middle, Earl Frank Thompson)	Maiden Surname)	•
2121 2121 Julid be fi Mental Junarked ic event,	ᆰ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Nu		ip Code) 21133
□ + = = = = = = = = = = = = = = = = = =	,	James K. Thompson Jr. (Son) 4278 Mary Ridge Dr. 1	<u>Kandallstou</u>	n Mo
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place)	20c. Location - City or To	own; State
E - 2 2 2 1		4 Domation 5 Other Specify: Garrison Forest VA 1117109	10 wings M	iris, MD
Balti permit Departu Imports injury o	1	21, Signature of Funeral Service Licensee 22. Name and Address of Facility Howell Hobb Liberty Heigh	Fuxeral de Aue, Bal	to MD 21207
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car fac or respirator ar failure. List only one cause on each line.		Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease		Death
}		or condition resulting in death) Due to (or as a consequence of):		
	je l	Sequentially list conditions, if any, leading to immediate Oue to (or as a consequence of):		
. 0	Examine	cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Oue to (or as a consequence of):		
executed an and an and an and	Sal E			
ਠੇ ਛੋਢੀ.	g	UNPENOEO AMENDEO		
876 tificate	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Oa	y Year
Box 68760, e death certificate be existent attending physician	Physician/Medi	1 Yes 2 No 9 Unknown 1 Unknown 1 Unknown 2 Unk		
c. the de	됩	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did	tobacco use contribute to th	e cause of death?
, P.O. res that the signed by be detach	ρ Ω	Chronic Alcoholism	es 2 No 3 Proba	bly 4 🗸 Unknown
ords w requi	흥	24a. Wat	ppsy prior to co	psy findings available mpletion of cause of
Division of Vital Records, tal or Attending Physician: The law require is after death. In Director: After this certificate has been side in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	Completed by	perf 1 ✓ Yes	ormed? death? 2 No 1 ✓ Yes	2 No
tal Recc cian: The lav certificate ha	Be	25. Was case referred to medical examiner? 25. Mas case referred to medical examiner? (Check only one)		
1 of Vi	유.	1 V Yes 2 No 1296 Detect follows 2 296 Detect follows 2 296 Detect follows 2 296 Detection of Mark 2 2	Residence 6 Other:	
ion of tending Pl eath. for: After the funera	tion	1 Natural 5 Pending (Month, Day, Year)		
VISION Alta fiter de Directe	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rura State)	Route Number, City
Spital	Ser	4 Homicide determined (Specify) 29a. Certifier A Continue Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the care		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit.	Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cat (Check only one) Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, dat	use(s) and manner as stated e and place, and due to the	i. cause(s)
To To COIT	Mec	and manner stated, 29b. Signature and title of certifier 29c. License number	29d. Date signed (Mont	
		My CO.C.M.E.	November 7, 2009)
11		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
Sta	ate			
Registr				

09-08641

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 36062 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER **Physician** Leslie Rena Vanessa Tucker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospice Ranallstown Balto If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕱 F 9-6-1955 Director 077-50-4688 54 S.C. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
is marked other than "natural" or items 330 or 300 feather. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at Director 1 XYes 2 ☐ No MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1915 Crestview Road 21239 ΙĬ S Α Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Black 1 ∐Yes 2 No Specify Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 years Elementary/Secondary (0-12) 12th grade Support Services SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivory G. Tucker Clara Eugene Droze ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a 1915 E. 32nd Street Balto, MD 21218 Stanley Tucker-Brother Department of Health Important: If item 27 any injury or other to once. 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 11-12-09 Randallstown,, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H h Avenue Balto, MD 21202 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC ISREAST CANCET /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical nse IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Physician: The certificate 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 ☐No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Of Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 5 ☐ Pending investigation 1 🛕 Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 5401 OLD COOKT ROAD Randallstown MD Sentor 2. Registrar's Signature 31. Date filed (A State Registrar

DHMH 17 Rev 1/2001

Funeral Director

show ed other than "natural", or items 23a or 28a-f show event, if a Medical Examinar must be rediffed at 2 should be filed within 72 hours after death with is and Mental Hygiene.
is marked other than "natural", or items 23a or ? permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evones.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-trar Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial

1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Margellen 20:23 Thomas 2009 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye October 8, 7: Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 1 □ M 2 🛣 F Months Days Hours Min. 212-28-9852 Maryland 79 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Director Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7811 Kavanagh Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ KNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XNo If Yes, Give Year or Dates: Specify. ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Clerk BGE 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis G. Clift William F. Drummey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2207 Frostburg Road, Frostburg, Maryland Susan Sommers niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville VA. Cem. Crownsville, Maryland 12, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, MD. there 23a, Part 1. Enter the disea le, i r complications that caused the shock, or heart failure. Lit only one cause on each line r complications that caused the de th. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 🗷 No Month Dav Year 5 Other (specify) 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 No Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 ⊠No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1K Yes 2 □ No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0069223 6. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 W. Read St Apt 704, Baltimore, MD 21201 Juan A. Morales-Tornes 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36064 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9:29A M **Physician** aylor OV /Medical 4c. County of Death Town, or Location of Death Facility Name (If not institution, give street and number, Examiner Kimor ecours If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 04-30-30 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 1 ☐ M **x2 万** F Yrs. 214-38-6659 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examination to putfled at X X Yes 2□No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Baltimore Street

12. Was Decedent Ever in U.S.
Armed Forces? Funeral 2504 W. 21223 USA 14. Race - American Indian, Black, White, et African 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: þ American 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Grace of Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' St. Peters Dietician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Carlton George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2122319a. Informant's Name/Relationship (Type. Print) Son 2504 W. Baltimore Street Baltimore, MD Massey Taylor, Jr. permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-16-09 Garrison Forest Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 MOD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6days **Physician** spiration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No Year Pregnant at time of death 5 Other (specify) signed by the a 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an cate has l', page 2 s autopsy To the Hospital or Attending Physician; The certificate 1 □Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral c 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No hours a er death. 2 Accident within 24 hours a er dealf

To the Funeral Director

completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Thomicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21223 2000 W. Baltimore St Bon Secours Hospital

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiana

		•	For State Registrar	State of IVI	aryiand /	-	irtment of Healt tificate of Deatl			eg. No. 7	000	20005	
			Decedent's Name (First, Middle,	*					2. Date of Deat	h	003	3. Time of Death	
	Physicia Medic		Myron	Tka	atch				Novembe:	r 9,	2009	9:33 A M	
4	Examin		4a. Facility Name (if not institution,				4b. City, Town, or Location	on of Death		4c. County of Death Baltimore			
م	Funeral		625 North Stuart 5. Social Security Number		e (In yrs. last bii	thday)		der 24 Hrs.	8. Date of Birth	_		place (State or Foreign	
	Director		141 12 3833	^{1 X M 2 □ F} 91		Yrs.	Months Days Hour	s Min.	July 25	, 1918	Penns	sylvania	
	how at	r	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	eation		-		1	0d. Inside City Limits	
	farylar Ba-f s tified	Director	Maryland Baltim	ore	Es	sex						1 ☐ Yes 2 X No	
	a or 2	I Dir	10e. Street and Number				10f. Zip Code		1	l 0g. Citizen	of What Cour	ntry?	
	th with ms 23 must	Funeral	625 North Stuar			1	21221				USA		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 Marr 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.			Vas Decedent of Hispanic Yes, specify Cuban, Mexi		ecify Yes or No- Rican, etc.)	1	Race - Americ Black, White, cify: Whi	etc.	
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g	be filed v ental Hyg ked othe ic event,	Be o	17. Father's Name (First, Middle, L	ast)					e (First, Middle, N	1aiden Surn	ame)		
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ē,	of Heal of Heal fitem ?		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of patory or other place)	_		•	on - City or To		
<u>=</u>	Page 1 ment of tant: If it ury or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Denation 5 ☐ Other (S	3 ☐ Removal from State pecify)	Bayvie	ew C	rematory Inc				more,	Maryland	
Baltimore,	permit. Page Department of Important: If any Injury or once.	375	21. So nature of Funeral Service	cep e	1	22. B:	Name and Address of Fa ruzdzinski F 407 Old East	cility Tunera Cern A	l Home P venue Es	A.	Marvla	nd 21221	
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- ,	Ph_sician/ Medical	į Jū	Immediate Cause (Final disease or condition resulting in death)	a	Fai	61	- fothi	~IV-C				Onset and Death	
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	cate be executed physician and s the burial-transit	cal E	resulting in death) Last	Due to (or as a	a consequence	Oi).							
3760		/ledical		d								_	
89 ×	n certif	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth		th 3 🗆	Ectopic pregnancy			23d.	Date of delive		
Bo	es that the death certifications by the attending poor be detached for use as	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 🗆	Other (specify)				Month	Day Year	
<u>0</u>	that th ned by detac	by Ph	Part II. Other significant condition	_	-			art I.	23e. Did tob	acco use c	ontribute to th	ne cause of death?	
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lita	sician certif irector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/C	ı ıtmatianı	26. Place of D			0 D (Dala	Α	
	ng Phy ter this neral d		27. Manner of Death 1 Natural 5 □ Pendin	28a. Date of inju	ry 28b.	Time of injury	28c. Injury at work?		ome 5 🔀 Reside 28d. Describe ho)	
lon	tendir Jeath. tor: Af the fu	Certificate:	2 Accident Investig	gation			M 1 ☐ Yes 2						
Division of Vital Records, P.O. Box 68	al or At s after o	Cerl	4 Homicide determ			arm, stre	et, factory, office	ļ	28f. Location (Str City or Town		mber or Rural	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of e Nurse Practioner: To the	xamination and/	or investi	igation, in my opinion, death	h occurred at	the time, date and	d place, and	due to the car	use(s) and manner stated.	
	To the Com		29b. Signature and title of certifier	200			29c. License numbe	559	3 2	9d. Date sig	9/27	Day, Year)	
	3		30. Name and address of person v	who completed cause of d	eath (Item 23a)	(Type, P	rint)	40	2/22	1			
	Star	0	31. Date filed (Month, Day, Year)	Y Mace	ar's Signatur	1	29 (tu;	-().	CIEC	/	<u> </u>		
	Registra		NOV 10	2009 Dien	a p.	136	Willes						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear 2:16 P M ROLAND TALMADGE TALTON JR. NOVEMBER 6, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BEL AIR HARFORD UPPER CHESAPEAKE MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 □ F Mary Land Director 219-03-0382 89 6, 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Evantian roughts in difficil at 1 ☐ Yes 2 ☐ No Director Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Glenwood USA Funeral Road 21014 death v 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Maryland 21215-0036 2 Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Chemical Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Be Roland Talmadge Talton Sr. Anna Louise Crockett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a <u> Annette Talton Fisher / Daughter</u> permit. Pages 1 and Department of Healt Important: If item 2; any injury or other t other 1 12020 Lake New Port Road, Reston, VA 20194 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐Other (Specify) Bethany Methodist Cem. 11-11-09 Pocomoke City, MD 4 Donation 21. Signa re Funeral ervice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tic Shod Physician days /Medical Due to (as a consequence of): **Examiner** urrent Chronic Lymphocytic Leukemia Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): attending physician The law requires that the death certificate be Physician/Medical as IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Division of Vital Records, P.O. Bo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 🗌 Unknown à ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 1 🗆 Yes 2 No 1 ☐ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0056296 November 6, 2009 54 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mesapeak Dr. Bel Air, MD 21014 3/10 baum, M.O N.O 500 Upper (31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08454 State of Maryland / Department of Health and Mental Hygiene Brigitte Renita Tubman 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2009 2124 hrs Tubman Renita Medical Examiner Brigitte 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Sinai Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Min Director 15 62 Country) MD 04212**-**78-8255 1 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No Baltimore NA MD 28a-f show notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21215 3019 Ferndale Ave items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married Yes è Black Specify 1 Yes 2X No specify: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", of or other traumatic event, the Medical Esaminer. Widowed Divorced f Yes, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private ltimore, MD 21215-0036 Care Giver lyr 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Burns Be Frank Tubman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3019 Ferndale Ave, Baltimore, Md 21215 Antoinette Tubman-Sister 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) Burial 2 X Cremation 3 Baltimore, Md 11/11/09 tant: On-Site Donation 5 Other Specify: 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, e of Funeral Service Licenses Baltimore, Md 21215 art I. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and ailure. List only one cause on /Medical Death Acute Necrotizing pneumonia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical ed by the attending physician detached for use as the burial -**X** UNPENDED 23a,PII,27,permE, g898 12/8/09 TT death certificate be Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy IE EEMALE 23b. Was decedent pregnant in the Month Day Year Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ģ NArcotic use Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician; Be examiner? Other_d Other Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No death. Pending To the Funeral Director: Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Dav, Year) 29c. License number 29b. Signature and title of certifie November 1, 2009 O.C.M.E. ee

Registrar

OCME 2006

State

30. Name and address of person who completed cause of death (Item 23a)

Victor Weedn MD JD

31. Date filed (Mental

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** hugs November 10:00 AM aumino 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner more Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) . Age (In yrs. last birthday) **Funeral** Days Year) Min. 1 M 2 □ F Months Hours Director Ma Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f shov Examirer must be notified at 1 ☐ Yes 2 ☐ No Director nmore 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 ☑No than "natural", or If Yes, Give Year or Dates Specify 3 ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institute Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. nnician is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ traumatic 0 n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important; If item 27 is any Injury or other trau Ramora Batto Mb 413 N ona W0000 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State torest 111 17/09 4 Donation 5 DOther (Specify) Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lib nsee Russ 2222 W. Noith MD 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PSis Sundrame **Physician** disease or condition resulting in death) /Medical of): Due to (or as a consequence Examiner ccted accubit if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician; The law requires that the death certificate be execute burial-tran that initiated events Box 68760, a resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by the a should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 2 🗌 No 1 □ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director 1 ☐ Yes 2 🔀 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ono or Attending 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 45148 duvember Rame and address of person who completed cause of death (Item 23a) (Type, Print) SECOURS HOSPITAL, 2000 WOST BULTIMORY STreet, ICARDO USURNO, Bul timera SON S 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indentities. 2009 amend #Islate of Maryland / Department of Health and Mental Hygiene 2009 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Jasumati Kalidas Vaidya **Physician** Jasmati 12:00 PM November 8, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burtonsville Montgomery 3504 Loma Linda Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2X F Yrs. Director 82 May 22, India 216-25-7630 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director Burtonsville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a of any Injury or other traumatic event: It is a state of the s Funeral 20866 United States 3504 Loma Linda Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ģ Specify: Asian-Indian 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mangaldas Dhanabhai Parekh Naniben Jethala 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harish Vaidya/son 3504 Loma Linda Court Burtonsville, Maryland 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 11/10/2009 W Arundel Crematory Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Funeral Service Licensee manita R. Homas 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 1 ☐ Yes 2 🗖 No Division of Vital 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signature

Gaurang Thaker, M.D.

D43430

3411 Olandwood Court, #105 Olney, Maryland 20832

State of Maryland / Department of Health and Mental Hygiene 36070 For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Earl Wyckoff 9 2009 4:00 A. M November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Cockeysville 114 Glenmoore Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, Year) 4/10/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 31∑€M 2 □ F 158-22-3413 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show traumatic event, the Medical Evan increment be notified at 1 ☐ Yes 2 ☐ No Cockeysville Director Maryland Baltimore 10g. Citizen of What Country?
United States 10f. Zip Code 10e. Street and Number death with ō 21030 114 Glenmoore Avenue or items 23a America Funeral 12. Was Decedent Ever in U.S. Armed Forces? ♣DIVes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 22 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Chief Warrant Officer 12 Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Mae Bigley John Henry Wyckoff ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 114 Glenmoore Avenue Cockeysville, Maryland Mrs. Mayona C. Wyckoff/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel Date 20a. Method of Disposition November 1 ☐ Burial 2 ☐ Dremation 3 ☐ Removal from State Forest Hill, Maryland 12, 2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8 Months Immediate Cause (Final a. Du to (or as a consequence of): CARCINOMA Physician disease or condition resulting in death) / /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed burial-transi Exami and Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ (Jiserse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been significate bases and page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1a betrs certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 \(\sum \) Nursing Home \(5 \) Residence \(6 \sum \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 038409 11/9/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HYIT WAVILLE MD, 2109] [275] F9115 Rd Sharran Willia M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Barko Registrar T A 5002

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wingfield Floyd 2009 November 3:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ouail Run Assisted Living Perry Hall 8. Date of Birth (Month, Day, Ye June 20, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1**X**] M 2 □ F Hours Virginia 228-42-7869 75 Director June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Baltimore Dundalk 1 Tes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2608 Plainfield Road 21222 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White "natural", 3 X Widowed 4 ☐ Divorced Specify: Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry alth and Mental Hygiene. 27 is marked other than "n r traumatic event, the Med (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Bethlehem Steel unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Dickinson Joseph Wingfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie Wingfield daughter 947 Barron Avenue, Essex, Maryland item 27 other tra 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place)

Dulaney Valley 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12, 2009 Timonium, Maryland Signature of Fundal Service Licenses ^{22, Name and Address of Facility} Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, Md. 21222 23a. Part 1. Enter the disease or complications that cause or heart failure. Est only one cause on each line. or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, Interval Betweer Immediate Cause (Final Onset and Death SING Physician, disease or condition Medical resulting in death) Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events Old and the burial-tran Due to (or as a consequence of resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death the be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) A 5517 Fee 1 ☐ Yes 2 🔣 No Other: မ 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of cortille 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 [] [] 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Watson Jack 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Franklin Square Hospita Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) May 26, 1920 5. Social Security Number (In vrs. last birthday Days Hours 1**X**M 2□ F 215-16-2189 89 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 X No Baltimore Dundalk Maryland 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 911 Dalton Avenue 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) 12 years Carpenter Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Howard Watson Helen Mary Mays 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diann Delaco Daughter 911 Dalton Avenue, Dundalk, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Russian Orthodox 11,2009 Elkridge, Maryland Signature of Funeral Service Licensee Funeral Home of Dundalk, P.A. witho 7110 Sollers Point Road, Dundalk, MD. 21222 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lostridium Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Kenal Disease, Type 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COPD autopsy performed? Yes 2 No 2 No Ashestosis 1 ☐ Yes 25. as case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Bulhnore

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21237

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examir or must be notified at

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene.

other t

permit. Pages 1 and Department of Heall Important: If item 2' any Injury or other once.

Watson, Jack H. Baltimore, Maryland 21215-0036

Funeral Director

Be Completed by

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that the death certificate be executed burial-tran attending physician for use as the burial

Box 68760,

P.O.

Records,

Division of Vital

signed t I be deta has page 2 certificate After this certific funeral director, Hospital or Attending death.

Physician/Medical Examiner n 24 hours after death.

In Funeral Director: A pletely filled in by the fu

Completed by Be Certification: To

1∐Yes 2 No

27. Manner of Death

1 X Natural

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month

29b. Signatury and title of certifier

3 Suicide

29a, Certifier

Hospital:

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

5 Pending investigation

6 Could not be determined

28a. Date of injury (Month, Day, Year)

and manner stated.

State

completely

the

Registrar

DHMH 17 Rev 1/2001

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

000 2. Registrar's Signature

28b. Time of Injury

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08675 State of Maryland / Department of Health and Mental Hygiene Charlie Williams 1- For State Certificate of Death Registrar 2. Date of Death Physician/ . Decedent's Name (First, Middle,Last) Month Day November 8, 2009 0143 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) NIA **Baltimore** University Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Country) Director 214-15-075 mary land 1 V M 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No items 23a or 28a-f show ust be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Yes Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygerer trant: If item 27 is marked other than "natural", on or other traumatic event, the Medical Examiner. 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 No specify: Specify ۾ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+ Elementary/Secondary (0-12) MD 21215-0036 Oth 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ ပ 19a. Informant's Name/Relationship (Type, Print 3019 Sea Ave Ba eto, mother man 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Dispositiop-Baltimore, crematory or other place) Cremation 3 Removal from State 09 Department o Important: metro Other Specify. 22. Name and Address of F nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician fail r List only one cause on each line. /Medical a. Multiple Gunshot Wounds Imme te Cause (Final disease ~xaminei or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine enuel. Enter Underhand Cross (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ

Division of Vital Records, P.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c, Location - City or Town, State Approximate Interval Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No. 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Hame 5 Residence 6 Inpatient 2 V ER/Outpatient 3 ۵ 1 Yes 28a. Date of Injury (Month, Day, Year) Nov 8, 2009 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: Subject shot 0000 hrs Natural 1 Yes 2 V No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 11 W 20th Street, Baltimore, Md (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 8, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month. egistrar's Signatu State Registrar DUME

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 55/PM WHITAKER W 2009 0 /Medical 4b City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number, Examiner BALTIMORE KANDALLSTOWN NURSING HOME KANDALLSTON N If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye 3–25–1936 Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Year **™** M 2□ F 246-52-0042 73 NC Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Gwynn Oak Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3834 Southern Cross Drive 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∕□ Yes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: African-American 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Lever Brothers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Whitaker Bertie Mae Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sallie H. Whitaker/Wife <u>3834 Southern Cross Drive, GwynnOak, MD 21207</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Garrison Forest Veterans 11-17-09 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Fonc P.A. of Baltimore Co. 21. Sign we of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part . Pinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 2 ☑ No DEMENTIA 1 🗌 Yes 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manyler of Death 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WHITEFOR

Year)

29c. License number ROS 4(5 /

9109 LIBERTY ROAD; RANDALISTOUN

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Royal Henry Wright 5:50 P^M 2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arcola Health & Rehabilitation Center Montgomery Wheaton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. 223-12-2815 92 9/22/1917 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show traumatic event, the Medical Evanimer must be notified at Director 1 X Yes 2 □ No MD Montgomery Wheaton 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. 23a 901 Arcola Avenue 20902 Funeral 72 hours after death or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. rmed Forces? ☑Yes 2 ☐ No Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: Black þ 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Driver Transportation 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaac Wright Mary Overby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 3194 5 Berry Road NE, Washington, DC 20018 Jewel Senior/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Regisrty 11/10/2009 Hanover, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature Funeral Service Licenses 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Lung Cancer months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or userying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 Unknown 9 Unknown ned by ti σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by sign be 1 ☐ Yes 2 ☐ No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 🔀 No I∐Yes 2 X No 1 ☐ Yes Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the within 2 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) D 09834 11/6/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

NOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# InerPHYS, G897, 11, 16, 09, WS.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wallo Sylvia /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elder care KaltiMore Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Funeral 1 □ M 2 👿 F Months Davs Hours Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examplean market has notified at 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? Street and Number 10f. Zip Code 21225 Cherryhill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: Specify: (Rack Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) h and Mental F ၉ ant's Name/Relationship (Type. Pages 1 and 2 Health a Baltimore, permit. Pages 1 and Department of Heat Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 Cremation
Donation 5 Other (5 3 Removal from State Zion 5 ☐ Other (Specify) Signature of Funeral Ser 11.21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Penjound Vamile Physician disease or condition resulting in death) /Medical Due to (or as & consequence of): Examiner man morrow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed Coma 12-10 and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ pe 1 ☐ Yes 2 ☐ No 3 Probably 4 → Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 (No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after deat the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 MD) 31464 Ó 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVIMO SI finte 30 & BALTIMOREMUYZO SIMIMI) 21

Registrar

State

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Ma	•	epartment of Certificate o		nd Mental Hy	giene Reg. N20	09	36077
	Physicia		1. Decedent's Name (First, Middle, Las	t)	l	vilson		2. Date of De Month	ath	Year 9	3. Time of Death 22: 40 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number	tal	4b. City, Town	o, or Location of D			ty of Death	
	Funeral Director		5. Social Security Number 6. Se		58 Y	nday) If Under 1 Years. Months Day		Min. (Month, Da	th ay, Year) 6 51	9. Birth	place (State or Foreign htry)
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
	he Mar 28a-fsl	Director	MD NA			Baltimor			10g. Citizen o	f What Cour	1 Yes 2 No
	3a or	Ö	10e. Street and Number 3014 Reistersto	wn Poad		Toi. Zip Cou	21215			S.A.	iu y :
	ems 2	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of		n? (Specify Yes or No Puerto Rican, etc.)		ace - Americ ack, White,	
15-0036	ours after al', or its Examina	by	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1 □ Yes 2√		dono i nodi, otoly	Spec		ack
7-C17	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or Items 23a or 28a-f show event, it of it safest Examinations that coffied at	Completed	15. Decedent's Edi (Specify only highest grade	ucation de completed) College (1-4or 5		Decedent's Usual Oc Give kind of work do. life. DO NOT use rel	ne durina most of	f working	16b. Kind of	Business/In	dustry
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	e d d	9 Be	17. Father's Name (First, Middle, Last) Willie Wilson				18. Mother's	Name <i>(First, Middle</i> White	, Maiden Surna	ame)	
	s 1 and 2 should t f Health and Men ftem 27 Is marke other traumatic	은	19a. Informant's Name/Relationship (7	ype. Print) Dauc	hter 19b.	Mailing Address (Stre			er, City or Tow	n, State, Zip	Code)
≥	# .1	3	Maria Wilson-Wi	lliams	42	3 Anstey	Road	Rustburg	, VA 2	24588	
	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	1	Disposition (Name of crematory or other)		Date 1/12/09	20c. Location Wood	•	
Бант		1	4 ☐ Donation 5 ☐ Other (Specify 21. Sign turn Funeral Service License		I WC	odlawn 22. Name and Ad	dress of Facility		woodi	Lawii	- Hu
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		V	23a. P. / 1. Enter the disease, or comp lock, or heart failure. List only of Imm diate Cause (Final				dying, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Top or	Physician /Medical	,	discase or condition resulting in death)	α.	a consequence o	easc					
	Examiner	L	Sequentially list conditions,	b							
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100,0	icate be executed physician and the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequence o):					
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O. DOX O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 nonths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregn. 5 ☐ Other (specify			I	ate of deliv Month	ery Day Year
S,	ires that signed by t be deta	þ	Part II. Other significant conditions of	entributing to death bu	it not resulting in	the underlying cause	given in Part I.	23e. Did	V/	ntribute to t	he cause of death?
ecords,	sw requ	Completed						24a. Was	an 24t	o. Were auto	opsy findings available
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5	ig Phy ter this neral di	n: To	27. Manner of Death	1 Inpatie 28a. Date of Inju (Month, Da)	y 28b. Ti	Jalleni 3 100A	4 ∐ Nursi njury at Vork?	ing Home 5 ☐ Res 28d. Describe	how injury occi		f <u>y)</u>
SIOIS	tendir leath. tor: Af the fur	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2 No				15
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•	3		30. Name and address of person who d	ompleted cause of d	eath (Item 23a) (ype, Print)	CLP	altimor	OVEMP	0 0	2001
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	N. Wsite	J1. 10	almylor	e, M.	V D.	48 /
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DHMH 17 Rev 1/2001

09-08299 Stephen Young

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36078 2009 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1 Decedent's Name (First Middle Last) Physician/ Month Day October 26, 2009 0439 hrs Medical Examiner YOUNG 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Birthplace (State or Foreign WASHINGTON) 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Davs MAY 30 1960 Director 49 Country) 579-78-6065 1 X M 2 DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No SILVER SPRING s 23a or 28a-f show e notified at once. MONTGOMERY MD 28a-f shov Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20904 531 RANDOLPH ROAD # 230-A Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after death wit nent of Health and Mental Hygiene. ant: If itien 27 is marked other than "natural", or items 5 or other traumatic event, the Medical Examiner must be 5 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' Never Married 2 Married 2X No Yes BLACK If Yes, Give Year 1 Yes 2 X No specify: Specify: Widowed 4 XDivorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 PRIVATE 2 YRS CHAUFFER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAVERNE JACKSON JAMES YOUNG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type, Print) 2 RANDOLPH RD # 230-A SILVER SPRING, MARYLAND LAVERNE YOUNG/MOTHER 20h. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 2 XCremation 3 Removal from State Burial 11/3/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY Donation 5 Other Specify 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 21. Signature neral Servi Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a Heroin intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury mai initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 23a,27,28a-f,permE, g897 11/13/09 TT ending physician use as the burial Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Month Dav Live birth Fetal death 2 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown signed by the att be detached for a Unknown 23e. Did tobacco use contribute to the cause of death? Q. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ 1 Yes 2 No 3 Probably 4 Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has performed? 1 🗸 No Yes 2 Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) uneral director. Be Division of Vital examiner? Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 🗸 Yes After 1 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification Yes 2 X No 1 unk Natural neral Director: / Pendina Fd 10/26/09 Fd 3:49 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2206 Weber_Dr 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide (Specify) found at home within 24 hours a

To the Funeral Heights, MD 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. October 26, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 31. Date filed (Month. 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36079 Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Ismail AZIZ 0620 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 13€ M 2 □ F Months (Month, Day, Year) 146-12-0473 Director 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 🛣 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17816 Pin Oak Road 21740 . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Divorced Specify: turkish Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) supervisor truck mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mustafa Aziz Yeagane Berkman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Mary Aziz - wife 17816 Pin Oak Road, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. cemetery, crematory or other place) Rose Hill Cemetery 10/31/09 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or condication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Grade Spindle Ezll High I simit disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Year signed by the a ld be detached f Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by secondary Smill Shock 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? disease 24a. Was an Jas • Hospital or Attending Physician: The 124 hours after death.
• Funeral Director: After this certificate heted filled in by the funeral director, page performed mellitus Dicheter 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ပ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year, 138764 10/29/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2H-8

State Registrar Rivers

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31. Date filed (Month Par

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egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#5 per INF, 10-30-09, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2009 9:15 am Gertrude. Auerbach Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1804 Pelling Court Silver Spring Montgomery 7, Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 🗆 M 2 🛛 F Months Hours 08/11/1927 washington, Director 82 Usual Residence of Decedent I Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maruland | Montgomeru Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1804 Pelling Court 20905 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve ည Esther Kleinhaus Isador Kahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5500 Friendship Blvd., #N2215, Chevy Chase, MD 20815 Ellen Copeland - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Lincoln Crematory 10/29/2009 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Signature of Funeral Service Licens, e 11800 New Hampshire Avenue. Silver Spring. MD20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 months Immediate Cause (Final Physician Metastatic Carcinoma, unknown primary site disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or se a consequence of, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the aftending physician and should be detached for use as the burlal-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 X No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 10/26/09 12 son who completed cause of death (Item 23a) (Type, Print) 12201 Plum Orchard Drive, Silver Spring, MD 20904 Lynn Rellosa, M.D., nth, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 36081 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Allan Brian Anderson 2009 October 2:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4641 Baugher Farm Road Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 □ F 562-02-6327 Yrs New York Director 54 1954 Dec 27, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 4641 Baugher Farm Road 21043 USA Funeral 72 hours after death or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 □Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Specify: White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygier 7 Is marked other the 5+ Software Engineer Computer Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvin Theodore Anderson Helen Stone 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 Is any injury or other trauonce. Candi Anderson/wife 4641 Baugher Farm Road Ellicott City, MD 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 10/26/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Adenerateirema OF Lune disease or condition resulting in death) 6 mon th) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diss to for as a consequente of Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> meningit Caranama tous 1 ☐ Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2X No certificate 1 □ Yes 1∐Yes 2∐No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation 1 □Yes 2 □ No after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D 30573 October 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 6020 12 Charter Dr Columbia, MB 21044 1070 31. Date filed (Mona Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 7:35 P ALBRIGHT October 0 MADEL INE Κ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Nursing Home and Rehab. Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 99 220-28-3989 13 1909 Maryland Director Dec. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Md. Rockville Montgomery 1 Tyes 2 WNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #227 20850 701 King Farm Blvd., United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Company Bookkeeper permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other ti any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kuehnle Freda 01ga John Heinz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clayton L. Albright, Jr. / Son 701 King Farm Blvd., #227, Rockville, Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IS Cremation 3 ☐ Removal from State Metropolitan Crem. 10/23/09 Alexandria, Va. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Muriel H. Barber Funeral Home Mouriel N. Barke P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Pulmonary Arrest disease or condition resulting in death) Due to (or as a consequence of) Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Cerebrovascular Attack attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hypertension IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 21 No Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2469 D 0067092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Weihan Wang, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Chrewa

15225 Shady Grove Road, Rockville, Md.

barke

09-08550 Paula Arnold Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Č	Certificate of Death	-	Reg. N	<u>. 2009</u>	3608
Physician/ Medical Examine		e,Last) Marie	Arnold		Date of Death Month Day November 3, 2	y Year 2009	3. Time of Death 2135 hrs
	4a. Facility Name (if not institution Memorial Hospital			vn, or Location of Death		4c. County of Death	
Funeral Director	5. Social Security Number 218–78–6888	6. Sex 7. Age (In your 1 M 2 X F 52	rs. last birthday) If Under Months		8. Date of Birth(MI	M/DD/YYYY) 9. Birti Foreigi	hplace (State or Maryland untry)
nd show any see.	Usual Residence of Decedent 10a. State 10b. County MD All		City, Town or Location Cumberland				10d. Inside City Limits 1 X Yes 2 No
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	10e. Street and Number 532 N. Cent	re Street	10f. Zip Co	21502	10g. C	itizen of What Coun	try?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 Yes 2 X N orced If Yes, Give Year	If Yes, specify (of Hispanic Origin? (Spec Cuban, Mexican, Puerto R No specify:		14. Race - Americ White, etc. Specify: W	can Indian, Black,
and 2 should be filed within 72 hours after and 2 should be filed within 72 hours after teath and Mental Hygiene. Item 27 is marked other than "natural". ITAMINATION BE COMPLETED IN TO BE COMPLETED IN 18	15. Decedent's Education (Special Elementary/Secondary (0-12)	College (1-4 or 5+)		g life. DO NOT use retire		. Kind of Business/Ir Entertai	
21215-0036 hould be filed within 77 hould be filed within 77 of Mental Hygiene, is marked other than tite event, the Medical To Be Comple		Last) William	Weisenmiller	18.Mother's Name (F	First, Middle, Maide Doroth		imble
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	Joshua S. Richa	ard / Son	532 N. Cer	Street and Number or Ru tre Street,	Cumberla	and, MD 2	21502
	20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Sp	3 Removal from State ecify:	Ob. Place of Disposition (Name crematory or other place) S.S. Peter & F		06/2009	Cumberlar	nd, MD
	21 Signature of Funeral Service	ldans	404 Dec	atur Street	, Cumberl	and, MD	21502 Approximate Interval
Physician /Medical	23a. Part N Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	cal meningitis		espiratory arrest, s	поск, от пеат	Between Onset and Death
i.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	ce of):				
euted nad ransit Examiner		Due to (or as a consequence d.	ce of):				
760, ficate be executed gphysician and the burial - transit	X UNPENDED	AMENDED 23a, 27, 1	perME, g898 12	/4/09 TT	12	3d. Date of delivery	
Box 6876 e death certificate the attending phy ed for use as the hvsician/M	past 12 months?	e 1 Live birth 4 Pregnant at time o	2 Fetal death	3 Ectopic pregnance)			ay Year
P.O. Bcres that the designed by the abedetached for but the detached for but the abedetached for but	•	ons contributing to death but n	ot resulting in the underlying ca	use given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
cords, law required has been a 2 should					24a. Was an autopsy performed 1 ✓ Yes 2	prior to co	opsy findings available ompletion of cause of S
f Vital Rec Physician: The arthis certificate ral director, page To Be Con	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	26. ✓ ER/Outpatient 3 DOA	Place of Death (Check on Other Nursing		dence 6 Other	
ion of lending Ph eath. for: After the funeral ation: T			1 ' ' 1	:. Injury at Work? 2	8d. Describe how it	njury occurred	
Division o ospital or Attending hours after death. meral Director: Aft y filled in by the fune Certification:	2 Accident Inves 3 Suicide 6 Could 4 Homicide	28e. Place of Injury - A (Specify)	At home, farm, street, factory, of	fice building, etc.	8f. Location (Street or Town, State)	and Number or Rur	al Route Number, City
To the Hosp within 24 ho To the Funa completely f		nysician: To the best of my know niner: On the basis of examination and manner stated.					
Me a serial Me	29b. Signature and title of certifie		1	icense number D.C.M.E.		Die Date signed (Mon Die Die Mondon (Mondon (M	
	30. Name and address of person Ana Rubio MD. Ass	istant Medical Examiner	111 Penn Street, Bal	timore, MD 21201		·	
State Registra		9 412 Begistrar Sig	Delue A. Sans	that			

To the

Registra

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 25, 2009

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

OCME

Victor Weedn MD JD

31. Date filed (Month, Day, Yea

ee

Assistant Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36085 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 25, 2009 5:00 A M **Physician** Leslie Mandell Berger /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Chevy Chase Montgomery 5610 Wisconsin Avenue #203 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) Months Days Hours 1 □ M 2 😾 F Washington, DC May 30, 1940_ Director 578-56-3814 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Eugenheem. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Directo MD Chevy Chase Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 U.S.A. 5610 Wisconsin Avenie #203 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 TNo Specify Specify δ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Travel Travel Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Herbert Mandell Libby Lorraine Bernstein 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6717 Michaels Drive Bethesda, MD 20817 Daniel Berger/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grds 10/28/2009 | Falls Church, Virginia 22. Name and Address of FacilityEdward Sagel Funeral Direction, 21. Signature of Funeral Service Licensee Edward Sage1 1091 Rockville Pike Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician led for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ZNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has page 2 s 2X No this certificate 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 1 Natural
2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00 1466666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 Arlington Blvd #500 Falls Church, Virginia 22042 DO Dona Leskuski, 31. Date filed (Month, Day, Year) State OCT 28 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 36086

	Physician
-	/Medical
1	Examiner
al C	

for State Registrar

			 Decedent's Name (First, Middle, La 	SI)		2. Date of Death Month	Day Year	3. Time of Death
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west,	/Medic		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Death		4c. County of Death	
	Examin	er	1	, 11 . , /	1		PA	
4 ¹			Laurel Kegion		ithday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthol	ace (State or Foreign
	Funeral		5. Social Security Number 6. S	Sex 7 7 Age (<i>In yrs. last bi</i> . 1 X M 2 □ F	Months Days Hours Min.	(Month, Day, Ye	ear) Count	'ry) .
	Director		1401.2		Yrs. 21	109/26/20	109 Mai	yland
	pu >	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	yn or Location		10	d. Inside City Limits
	shov	_	10a. State 10b. County	Toc. Oity, Tow				1 Des 2 □ No
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	ms 2	Jer	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	specify Yes or No-	14. Race - America	
_	iner iter	Ē	1 Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 □No	· ·	to Rican, etc.)	Black, White, e	ic.
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Exteringer must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □Yes 2 No Specify:		Specify: Bla	CK
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7	withi ene. thar	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	None			
N	Hygi Hygi Ither nt, I	ပိ	17. Father's Name (First, Middle, Last		18. Mother's Nar	ne (First, Middle, Mai	iden Surname)	
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g n	permit. Page Department of Important: If any injury or once.			Ku C	Laurel 12 cg. 1	1-cs11,1-c	e .	90
			OD: Death Enterthe disease execu	enlications that saveed the death. Dr	not enter the mode of dying, such as cardia	c or respiratory arrest		Approximate
			shock, or heart failure. List only	one cause on pach line.	w w		Plan.	Interval Between Onset and Death
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	/Medical		resulting in death)	Due to (or as a consequence	e of):			
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	_	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	s ofly:			
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8	ath cert ttending or use a	ian/Med	23b. Was decedent pregnant	23c, If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deal	th 3 ☐ Ectopic pregnancy		23d. Date of deliver	ery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2357pM ATHERINE BAXTER COCHRAN OCTUBER. 24,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner HOSPITAL LENTER KENT RIVER CHESTERTOWN HESTER Year If Under 24 Hrs. 8. Date of Birth

Davs Hours Min. (Month, Day, Year) If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Director 16 6937 12/30/1929 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at HESTERTOWN 1 Yes 2 No MD KENT Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ANNON USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OCH RA KED ၉ 416504 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EDGEWOOD READ Pages 1 and 2 s ment of Health ar MADISON, NI 07940 REBECLA permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tra once. ${\mathcal B}$ 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 10/26/09 3 Removal from State HESTERALE CREMONO 21. Signature of Mineral Service License FUNEER DIRECTO WILLIAMS, JA MARYIN RUAD CHESTERTOWN 21620 130 5088 C 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Emor-hasic Immediate Cause (Final disease or condition resulting in death) 0 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent preg 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion it cause of death? 24a. Was an autopsy performe this certificate 2 No 2 □No 1 ☐ Yes 25. Was case referr examiner? Be to medical 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**7**-No 1 Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To 27. Maryer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death hours after death uneral Director: completely filled in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 10 0 26 rson who completed cause of death (Item 23a) (Type, Print peer Rd Bldg B Chestertown MD. 21620

DHMH 17 Rev 1/2001

State Registrar

Nathaniel Jerom		State of Maryland / Department of Fleath		ygiene		
Physicia		1- For State Registrar 1. Decedent's Name (First, Middle,Last) Certificate of Death		2. Date of Deat		009 3608
Medical Exami		Nathaniel Jerome Brown		Month October 2		0650 hrs
and the same of th			wn, or Location of Death		4c. County of	Death
Ţ		Prince George's Hospital Center Chever	1y		Prince Ge	eorge's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months				g. Birthplace (State or Foreign Washington
Director		578-08-5612 1X M 2 F 28 Yrs.	Days Hours Will	Oct. 1	4, 1981	Country) DC
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
*	_	District of Columbia Washington				1 X Yes 2 No
Aaryland 28a-f show 1 at once	Director	10e. Street and Number 10f. Zip C	ode	1	0g. Citizen of Wha	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be n. iffied at once		2304 Hartford Street, SE #201 200	20		United	States
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r deatl	Ē	1 Yes 2 X No	Cuban, Mexican, Puerto	o Rican, etc.)	White,	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	ខ្ញ	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	Maiden Surname)	
d be f fental narkec	Be	Nathaniel Jerome Brown, Sr.	Beatrice			
MD 2 d 2 shoul Ith and N n 27 is n	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 2.1.0 // 2.md	(Street and Number or I			
e, N and 2 Health item 3		20a. Method of Disposition 20b. Place of Disposition (Name		Date Date		City or Town, State
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altir mit. P partme portal	1		ddress of Facility St			
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To To	ĕ	and manner stated. 29b. Signature and title of certifier 29c. I	License number		29d. Date signed	d (Month, Day, Year)
		Carol Hallan	O.C.M.E.		October 22,	2009
R 2	r	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Ba	altimore MD 2120)1		
Sta	te		, = 120			
Registr	ar	31. Date filed (Month, Day Year) OCT 2 8 2009 Common S. Agarks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36089 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Charles Wilbur Brooks 2000 /Medical 4c. County of Death Harford 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bel Air Examiner Upper Chesapeake Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 8 - 2 8 - 1 9 4 9 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 60 218-52-2108 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Evancians in ust be nutified at Director Maryland Havre de Grace Harford 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 144 Wilson Street 21078 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Myes 2 No If Yes, Give Year or Dates: 1970-72 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Specify Be Completed by 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Inc. Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 Wright Mill Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Brooks ပ္ Martha Zellman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Earlton Road, Havre de Grace, Maryland 21078 Sandra L. Hartman (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-31-2009 Darlington, Maryland Darlington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zollman Function Home, P.A. 21078 123 S. Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SANGUINATIO HIR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown director, page 2 should be det Part II. Other significant conditions/contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 1 ∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Vital

11800516170 |0|30|0|8 Baltimore, Maryland 21215-0036

Pages 1 and 2 should be f nent of Health and Mental

attending pl Attending Physician: this after death Director: filled in by Hospital or To the Hospital within 24 hours a To the Funeral D completely

Medical

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Viola Blevins Month 2009 Medical October 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Stella Maris</u> Baltimore Timonium 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 217-24-2022 1 M 2 X F Months Days Hours (Month, Day, Year) 79 Director March 1930 Maruland Usual Residence of Decedent 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Havre de Grace 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 720 St. James Terrace 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 \square Widowed 4 \square Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Rotail Salos 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Stankwich Emma Albricht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melinda Craig (Daughter) 453 Congress Avenue, Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens: 10/30/2009 | Aberdeen, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington Street, Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Pregnant at time of death ☐ Unknown 5 Other (specify) Month Day Year signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performa After this certificate funeral director, pag 1 Tes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: ၉ 1 Yes 4 Nursing Home 5 Residence bille 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? 2 NO Accident Investigation 6 Could not be Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicities: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check unity uni 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) monium MD21043 Registrar's Signature State Registrar

Baltimore,

Records,

of

Division

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Fh G897 11/18/09 TT Health and Mental Hygiene 2009 36092 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ CTON EX Baugh Mack Ε. 10:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Washington Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) 1937 Goochland, VA **Director** 480-40 Usual Residence of Decedent fshow 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director PA Franklin State Line 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a Funeral 15356 Skyline Dr. 17263 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1

Yes 2

No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. **Black** Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 owner retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ McDonald Baugh Racie Barrett permit. Page 1 and 2 shou Department of Health and Important: If Item 27 is m any Injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Baugh 9775 Browns Mill Rd. Greencastle, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Greencastle, PA Cedar Hill Cemetery November 6, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licenses Miller-Bowersox Funeral Home 22. Name and Address of Facility Doverson 521 S. Washington St. 17225 Greencastle, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Massive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): -Pinialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months' Month Day Pregnant at time of death Year the 9 Unknown 9 Unknown P.O. detach ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of dear þ Division of Vital Records, Completed 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ✓ nknown ype lipidomia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy certificate Yes 2 4 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{\text{Nesidence}} \) 1 \(\text{\text{Residence}} \) 2 \(\text{\text{Other}} \) 1 \(\text{\text{Other}} \) 2 \(\text{\text{Nursing Home}} \) 2 \(\text{\text{Nursing Home}} \) 3 \(\text{\text{Nursing Home မှ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral of 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 🗆 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Decella OCTUBA 110061117 E. AnTIFTam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 Sestoun ancisco 21740 31. Date filed (Month, Day, Year) 32 Registrar's Signature State BULL

∂[¢] DHMH 17 Rev 7/2009

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Registrar

ORIGINAL

09-08109 Corey R Clites

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 36093

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Physicia		Registrar 1. Decedent's Name (First, Middle,					2. Date of Death		3. Time of Death
edical Exami	ner	COKEY K	AY CLI	1ES	Tab Ciby To	own, or Location of	October 18	3, 2009 4c. County of Death	1836 hrs
		4a. Facility Name (if not institution, Memorial Hospital	give street and number)		Cumb		Death	Allegany	
Funeral			. Sex 7. Age	(In yrs. last bi				h(MM/DD/YYYY) 9. Birt	
Director			X M 2 F	32	Yrs. Months	Days Hours	Min. AUG.		untry) MD
ıny		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limits
nd show a	ŗ	PA BED	FORD	HYN	OMAIN				1 Yes 2 X No
Maryla 28a-f d at or	Director	10e. Street and Number		00	10f. Zip			g. Citizen of What Cour	ntry?
death with the Maryland or items 23a or 28a-f show any must be notified at once.	al Di		E HALL	KU		15545		USIA	can Indian, Black,
eath w items	Funeral	11. Marital Status 1 X Never Married 2 Mari	ied 12. Was Decedent E Armed Forces? 1 Yes 2	No No		y Cuban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	White, etc.	
after d	by Fi		or Dates:			✓ No specify:			hite
hours "natur	ted I	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indus during most of working life. DO NOT use retired)							ndustry
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215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica	o⊃ €	17. Father's Name (First, Middle, L	Clites	•			Name (First, Middle, N	Maiden Surname) Shaffe 1	
212' ould be Mental marke	o Be	Kenneth F. 19a. Informant's Name/Relationshi		11	b. Mailing Address	(Street and Numb	er or Rural Route Num	ber, City or Town, State	, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once			Clites/Fath					AN PAIS	545
of Heal If item		20a. Method of Disposition 1 💢 Burial 2 Cremation	3 X Removal from Star	crema	of Disposition (Nam atory or other place)	1	Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of Hea Important: If itel		4 Donation 5 Other Spe 21. Signature of Funeral Service ↓	cify:	Palo 1	Alto Hillto	P Cem.	10-21-09	HUNDMAN 69 Clarence	3 PA
Bal permi Depa Impo injur		THE SIGNATURE OF FUNERAL SERVICES	it is a second of the second o				r F.H. Inc	Hyndman P	A 15545
Physician		23a Part I. Enter the disease, or confailure. List only one cause of	omplications that caused to each line.	the death. Do r	not enter the mode o	of dying, such as ca	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical caminer		Immediate Cause (Final disease or condition resulting in death)	a. Head and Neck						Death
		Sequentially list conditions,	b.	que 100 01).					
	nine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):					
ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
760, icate be executed physician and the burial - transit	Medical	UNPENDED	X AMENDED 20	. 1	ME -007	7 11/19/0	0 mm		
760, icate be physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom		r ME g897			23d. Date of deliver	•
Box 687 e death certification at the attending at for use as t	sician/	past 12 months?	1 Live birth 4 Pregnant at t	time of death	Fetal death Other (Spec		pregnancy	Month	Day Year
, P.O. Box 687 res that the death certification is generally by the attending be detached for use as the detached for use as t	Phys	1 Yes 2 No 9 Unkn	9 Olikilowii	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		anne sines in Dec	L I 220 Did to	obacco use contribute to	the enume of death?
P.O.	by	Part II. Other significant conditio	ns contributing to death	but not resulti	ng in the underlying	cause given in Par		s 2 ✓ No 3 Pro	
Division of Vital Records, tal or Attending Physician: The law require is after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed						24a. Was		utopsy findings available
Vital Records, ysician: The law requirents in certificate has been so director, page 2 should	omp			_				rmed? death?	,
ian: T	Be C	. 25. Was case referred to medical examiner?			2	26.Place of Death (Check only one)		
of Vit ing Physic After this	To	1 Yes 2 No 27. Manner of Death	28a Date of Injur	nt 2 🗸 ER/		OA Other 4 28c. Injury at Work?	Nursing Home 5	Residence 6 Othe	r:
on of \ ending Phy ath. r: After tl he funeral	Certification:	1 Natural 5 Pendir	FOUND: Day, Ye	FC FC	UND:	1 Yes 2 ✓	Operator of	ATV-fixed object	collision
VISIO or Atte firer des Directo in by t	ifica	2 ✓ Accident Investi 3 Suicide 6 Could	28e Place of Ini		5:30 pm farm, street, factory,	, office building, etc		Street and Number or Ri	ural Route Number, City
Spital hours a neral 1	Cert	4 Homicide determ	(0,000.)/ [000					State) d, Fairhope, PA	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Pinneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transi	Medical	(Check only Centrying Priy	sician: To the best of my iner:On the basis of exan						
To wit To	Mec	29b. Signature and title of certifier	and manner stated.		290	c. License number		29d. Date signed (Mo	onth, Day, Year)
3		arol	Hall	air		O.C.M.E.		October 19, 200	9
nes		30. Name and address of person w Carol Allan, MD Assi	ho completed cause of de stant Medical Exan) I Penn Street, I	Baltimore MD	21201		
	tate	·		4- 0:					
Regis		31. Date filed (Month, Day Year) OCT 22 20	09 Deneur	pl. 14	barres				

DHMH 17 Rev 1/2001

ORIGINAL OGME

			1 - State of Management of Man	•	epartment of I Certificate of L			ene _{g. No.} 2009	36094
	Physicia		Decedent's Name (First, Middle, Last) DORCAS ELIZABETH CAPEL				2. Date of Death OCTOBER	25 2009	3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location of Death	Journal	4c. County of Deat	h
	Funeral		201 CHURCH LANE 5. Social Security Number 6. Sex _ 7. Age	e (In yrs. last birtho	tay) If Under 1 Year	SONVILLE If Under 24 Hrs.	8. Date of Birth	QUEEN A	hplace (State or Foreign
	Director		226-76-2255 1 ☐ M 2 🕱 F Usual Residence of Decedent	57 Yr	s. Months Days	Hours Min.	DEC. I,	1951 VII	GINIA
	/land f show d at	tor	10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	or 28a-	Direc	MARYLAND QUEEN ANNE 'S 10e. Street and Number		GRASON 10f, Zip Code	WILLE	10	ng. Citizen of What Co	1 🗌 Yes 2 🗶 No
	is 23a o	Funeral Director	201 CHURCH LANE			1638		UNITED STA	
Maryland 21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 ☐ Never Marrled 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	ver in U.S. No	13. Was Decedent of H If Yes, specify Cuba1 ☐ Yes 2 X No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: WH]	e, etc.
15-(72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	(0	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired)		ing 1	6b. Kind of Business	Industry
212	ygiene ygiene her tha nt, the	Be Co	Elementary/Seconday (0-12) College (1-4 or 5	+)	D AND BEVER	RAGE MANAG	GER	HOSPITA	LITY
land		To B	17. Father's Name (First, Middle, Last) MALON LEE WHITLOW				e (First, Middle, Ma CAS MARIE	,	
Aary	short		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street				
re,	1 and 2 sif Health item 27 other tra		JOHN E. CAPEL/HUSBAND 20a. Method of Disposition	20b. Place of D	O1 CHURCH L			0c. Location - City or	
Baltimore,	. Page tment o tant: If jury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CREMAT	crematory or other place HESAPEAKE ON CENTER	e) OCTO	BER 26 2 09 S'	TEVENSVILL	E, MARYLAND
Bai	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti	l di	21. Signature of Funeral Service Licensee			ss of Facility ELFENBEIN CK ROAD	AND NEWI	NAM FUNERA	L HOME, P.A.
ı			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) A RESP Due to (or as a	RATO a consequence of):	DRY HA	ILURE	DUE	TO	Onset and Death
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	i consequence on.					
	certificate be executed nding physician and use as the burial-transit	al Ex	that initiated events resulting in death) Last C. Due to (or as a	consequence of):		.			
3/60	ficate b g physi as the t	Aedical	d				_		
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal death	3	çy		23d. Date of del Month	ivery Day Year
О.	es that to igned by be deta	by	Part II. Other significant conditions contributing to death but	ut not resulting in t	he underlying cause giv	ven in Part I.	11 /	cco use contribute to	
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Vita	sician: certific lirector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	a \Box FD/2 +-	Othe	ace of Death (Checker:			
0	ng Phy fter this ineral d	ate: To	27. Mannef of Death 1 Natural 5 Pending (Month, Day,		ne of 28c, Injury	/ at	me 5 M Residen 28d. Describe how	ce 6 Other (Speci injury occurred	fy)
DIVISION	Attendi r death. ctor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	rv - At home, farm		Yes 2 ☐ No	28f Location (Stre	et and Number or Rur	al Route Number
<u>></u>	ital or / Ins after ral Dire		building, etc.	. (Specify)			City or Town,	State)	·
	ne Hosp n 24 ho ne Fune oleted fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of received the desired form of the basis of expension of expension of the basis of the basi	amination and/or in	ivestigation, in my opinic	on, death occurred at	the time, date and	place, and due to the c	ause(s) and manner stated.
	To the To the COTIF		29b. Signature and title of certifier		29c. License	number		d. Date signed (Month	
			30. Name and address of person who completed cause of de	eath (Item 23a) (Tyr.		6818		101.56	09
			Avun Bhandavi 31. Date filed (Month, Day, Year) 32 Registrar	M.d	1630 M	ainst	Suite	,204 cn	ester Md
	Stat Registra		OCT 26 2009	Signature					2101

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	1- For State Registrar	Certificate	of Death	Reg.	No. 200	9 3609
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Thadius Duckwo			October 21,	2009 Year	3. Time of Death 2121 hrs
	4a. Facility Name (if not institution, give street and Memorial Hospital	1 number)	4b. City, Town, or Location of Dec Cumberland	ath	4c. County of Death Allegany	
Funeral Director	5. Social Security Number 6. Sex 236-45-0260 1X M 2	7. Age (In yrs. last birthday		8. Date of Birth of Min. 09/28/	MM/DD/YYYY) 9. Birth 1998 Foreign Cou	place (State or ntry)Maryland
Maryland 28a-fshow any datonce. ector	Usual Residence of Decedent 10a. State 10b. County Allegany 10e. Street and Number	10c. City, Town or Lo		100	. Citizen of What Count	10d. Inside City Limits 1 XYes 2 No
the Maryland a or 28a-f sh tiffed at once	15617 Mt. Savage	Road, N.W.	21545	Tog	U.S.A.	,,,,
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural"; or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 X Never Married 2 Married 1 Yes Yes 3 Widowed 4 Divorced If Yes Grates:	d Forces? es 2 X No Year 1	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	14. Race - Americ White, etc. Specify: Wh 1	te
-0036 siene, vithin 72 hour giene, her than "natu her than "natu than dical Exan ompleted	15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) College		dent's Usual Occupation (Give kind g most of working life. DO NOT use		6b. Kind of Business/In	
-003(d within /giene. ther that the Medic	5 17. Father's Name (First, Middle, Last)		student 18.Mother's Na	ime (First, Middle, Ma	studer	nt
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO BE COMPIE	Eric Duckworth			ndy McMi		
MD 21 d 2 should dith and Me an 27 is ma aumatic en	19a. Informant's Name/Relationship (Type, Print) Eric Duckworth		illing Address (Street and Number $914~6 h$ Avenue			
MOFE, Pages 1 an ient of Hea int: If ite	20a. Method of Disposition 1 X Burial 2 Cremation 3 Remov 4 Donation 5 Other Specify:	al from State crematory o		10/26/09	20c. Location - City or T Frostburg	, Md
Balti permit. Departm Imports injury o	21. Signature of Funeral Service Licensee	exet 2	2. Name and Address of Facility D 57 Frost Ave.	urst Fun ,Frostbu	eral Home rg, MD 21	532 P.A.
Physician /Medical	23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.		er the mode of dying, such as cardia	c or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Multiple Due to (or	Injuries as a consequence of):				Death
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	23b. Was decedent pregnant in the past 12 months?	res, outcome of pregnancy ve birth regnant at time of death 5	Fetal death 3 Ectopic pre Other (Specify)	gnancy	23d. Date of delivery Month D	ay Year
P.O. Es that the ces that the ces that the ces detached by the cest detached I by Physical Ph	Part II. Other significant conditions contribution		he underlying cause given in Part I.		acco use contribute to t	
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tal Re(ciau; The certificate rector, page	25. Was case referred to medical examiner?		26.Place of Death (Che			
n of Vit ding Physic a. After this funeral dir	1 ✓ Yes 2 No 1 27. Manner of Death 28a. I	Inpatient 2 FR/Outpat Date of Injury 28b. Time		28d. Describe ho	esidence 6 Other	
_ = `~~ A	2 Accident Investigation	lonth Day Year) 21, 2009 2017 hrs	1 163 2 160		otor vehicle collis	
Division of tealing and or Attending us after decented and Directors. After the function by the function:	Suicide Could not be	Place of Injury - At home, farm, s cify) Interstate/Express	street, factory, office building, etc.		reet and Number or Rus ate) ed Hill, Lavale, MD	al Route Number, City
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director, ledical Certification: To Be (OD- Codifica	isis of examination and/or inves	ccurred at the time, date and place, tigation, in my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as state nd place, and due to the	d. e cause(s)
M F % F %	29b. Signature and title of certifier Car of Hal	lan	29c. License number O.C.M.E.		29d. Date signed (Mor October 22, 2009	
per	30. Name and address of person who completed Carol Allan, MD Assistant Medic	,	nn Street, Baltimore, MD 21	201		
State Registrar	1 HEEL 2/6 7009 L	P. Fegistrar's Signature	barket			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08192 State of Maryland / Department of Health and Mental Hygiene Tana Lynn Davis 2009 36096 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 21, 2009 2024 hrs Davis Tana Lvnn Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Allegany Route 40 Lavale Red Hill 1 1/2 Mile West of Lavale Lavale 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number Funeral Foreign Maryland
Country) Min Months Davs Hours 218-04-7703 Director 11/19/1977 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No MD Allegany Mt. Savage 28a-f show or items 23a or 28a-f shormust be notified at once. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21545 12722 Cobblestone Road 14 Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? hours after death 1 Never Married 2 Married Yes 2 X No Yes 2 X No specify: Specify Pages 1 and 2 should be filed within 72 hours after trment of Health and Mennal Hygiene.
 Trant: If item 27 is marked other than "natural", or yor other traumatic event, the Medical Examiner. 4 X Divorced Widowed f Yes. Give Year ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Driver MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Davis Jackiline Parson Elmer Calvin Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 229 Baltimore Ave, Apt 603, Cumberland, MD 21502 Elmer Calvin Davis / Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Cumberland Crematory 10/23/2009 Cumberland. MD Donation 5 Other Specify: 22. Name and Address of Facility Alams Family Funeral Home, P.A. 21 Si nature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ed by the attending physician a detached for use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions ۾ 1 Yes 2 No 3 Probably 4 V Unknown

P.O. Records,

the Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been s ector, page 2 should director, this After the

Completed 25. Was case referred to medical æ 27 Manner of Death Certification:

examiner?

1 Yes

Natura

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

2 🗸 Accident

1

3

(Check only

Medical

State

No

Pending

Investigation

Could not be

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital

2 ml

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year)

OCME

24a, Was an

✓ Yes 2

or Town State

Nursing Home 5

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 ✔ No

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

autopsy performed'

28d. Describe how injury occurred

Passenger auto auto collision

24b. Were autopsy findings available

death?

Residence 6 V Other: Scene

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

Route 40 Lavale Red Hill 1 1/2 Mile West, Lavale, MD

October 22, 2009

1 V Yes

prior to completion of cause of

ER/Outpatient 3

28b. Time of Injury

2017 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

Inpatient

(Specify) Interstate/Express

28a. Date of Injury

Oct 21, 2009

and manner stated

State of Maryland / Department of Health and Mental Hygiene. 36097 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Edward Davis Richard 23, October 2009 7:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10 N. Liberty Street, Apt #609 Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Funeral Days Months 1 X M 2 □ F 79 220-28-9347 Yrs. **Director** 09/02/1930 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shor Examiner must be notified at Director MD Cumberland 1 X Yes 2 □ No Allegany 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10 N. Liberty Street, Apt #609 USA 21502 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Follows, IMYes 2 No 'Vas Give Korean Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 □Yes 2 🗓 No Specify Specify: 3 Widowed 4 Divorced White 'natural" War Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "ne any injury or other traumatic event, if a Music once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Plate Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethelbert Davis Margaret ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronelda Davis / Wife 10 N. Liberty Street, Apt #609, Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Park | 10/28/2009 | Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Sign turn of Funeral Service Dicensee 404 Decatur Street, Cumberland, MD Approximate
Interval Between
Onset and Death
Cone Lour 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac in respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2☐No 3☐ Probably 4☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 🗷 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1∐ Yes 2 7 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural hours after death. 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after des To the Funeral Director completely filled in by th 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22181 October 23, 2009 mll ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed L. Wagoner M.D., 925 Bishop Walsh Road, Cumberland, MD Gary 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 26 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36098 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2009 A M Ruth Marie Denton 2:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Asbury-Solomons Health Care Center Solomons Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Ost Virginia Days Months 1 🗆 M 2 💢 I Hours 0117171941 Director 233-70-9053 68 West Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎇 No Solomons Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11450 Asbury Circle, Apt. 428 20688 United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: White 3 ♥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Church pernit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Hendricks Bessie Hamilton Osbourn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 684, Edgewater, Maryland 21037 Julie Denton / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Church Cemetery 10/26/2009 Port Republic, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ a CENTRAL NEEVOSSYSTEM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death by the a g Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy r this certificate has eral director, page 2 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be funeral director 26. Place of Death (Check only one) examiner? Hospital Other: 2 CHNO မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director: Af
I filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, npleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2
To the comple 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar TO HA

31. Date filed (Month, Day, Year)

RINCE

WEIGER

32. Registra s Signature

CRAD FRICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Manylands/259920168169 Health and Mental Hygiene 2009 36099 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2009 CHARLENE DRAPER 7:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Sep. 14 Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗔 🕏 Months Days Hours Director Sep. 416-88-7287 47 AT. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 No Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral filed within 72 hours after death with 9114 Bank St. 20613 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 9 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No If Yes, Give Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates Black er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill F Health and Mental Item 27 is marked 2 Earnest Cross Emma Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keesha Draper-Daughter 9114 Bank St. Brandywine, Md. 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗖 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery : 10-28-2009 Cheltenham, MD. Signature of Funeral Service Licenses Marshall s Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of Examiner se Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequent 200 Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans CERTIFICATION APPROVED BY MEDICAL EXAMINER that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectonic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Other (specify) ☐ Pregnant :
☐ Unknown Pregnant at time of death signed by the a 9 Unknow P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 3 ☐ Probably 4 ☐ Unknown No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) examiner? Other: Certificate: To ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 28a. Date of injury (Month, Day, Year) funeral 27. Manner of kath 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work' s after death. 1 🗌 Yes 2 🗌 No the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Day Year **Physician** DARDEN LASHEA M. HODER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) Funeral Months Days Hours 1 ∏ M 2 😿 F WASHINGTON, DC Director 7-05-1975 34 577-11-5216 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Modical Exemples must be notified at 1 XYes 2 □ No **Funeral Director** MD PRINCE GEORGE'S LANHAM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 USA 9919 GOOD LUCK ROAD APT T-1 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No BLACK Specify: Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR PRIVATE 12TH Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H tem 27 is marked ott JOAN DAVIS EDMOND DARDEN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20706 9919 GOOD LUCK RD Apt T-1 LANHAM, MARYLAND EDMUND DARDEN/FATHER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND 5 ☐ Other (Specify) RIVERDALE CREMATORY 10-27-09 4 □ Donation 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Edneral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachyline. pproximate nterval Between nse and Death Immediate Cause (Final disease or condition resulting in death) tano **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar to (or as a consequence of): Physician/Medical as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 1 ∐Yes 2 LivNo P.0. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Officer significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Physician: The 2 5 1 ☐ Yes of Vital 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 200 Certification: To 1 Inpatient 2 Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check on one) the 29d. Date signed (Month, Pay, Year) 29b. Signature and title of State 2 8 2009 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2009 1 - For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death onth Day Month **Physician** 11.41AM Gran 2009 gare /Medical 4c. County of Death Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. Hours Months Days 1 □ M 2 🖫 F 08/24/1942 Director 67 NJ 157-32-6293 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Evaminer must be notified at 1 □Yes 2 X No Director Arundel Co. Linthicum Heights MD Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Co ō 23a 21090 United States Funeral 229 Sycamore Road items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ② No 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 21 Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 27 No Specify If Yes, Give Year or Dates Š Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) filed withir Hygiene. Homemaker Own Hame is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Buttice Joseph Grano ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a 114 Sycamore Road Linthicum Heights, MD 21090 Chad J. Doran - son permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2009 Ellicott City, MD St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) M0104422. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA 7 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MULTIPLE years MYELOMA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-transi Exam Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 5 Other (specify) P.0. the 9 ☐ Unknown 9 Unknown signed by t 1 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has l page 2 s autopsy performed? 1 XYes 2 No certificate **Division of Vital** Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending n 24 hours and he Luneral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the

Registrar

29b. Signature and title of certifier

31. Date filed (Month CT

, MEDICAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIMKETKAI

DOCTOR

egistrar's Signature

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

Baltimore MD 21287

OCTOBER, 24. 2009

3altimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

State Registrar 29b. Signature

BAHRAM PISHDAD M.D. 31. Date filed (Month, Day, Year)

OCT

and title of certifie

7801 OLD BRANCH AVE #409

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27 2009

CLINTON, MARYLAND

1) 51520

29d. Date signed (Month, Day, Year) 10-27-2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 25, **Physician** 2009 2:41 Margaret Karen Dunnington /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 □ M 2 □ 🛣 218-52-5815 58 Washington DC Director Feb. 21, 1951 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exertient and be notified at 1 ∐Yes 2 ∐XNo Director Charles Waldorf Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 12623 Council Oak Drive 20601 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ∭Mo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: Black \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Administrator Phone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret A. Tolson James D. Jackson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. 12623 Council Oak Dr., Waldorf, Md. 20601 Randolph Dunnington Husband altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 30, 1 Burial 2 □ Cremation 3 □ Removal from State 2009 St. Joseph Catholic Church Pomfret, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640 M00668 Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the ar 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has t lirector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 - No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Impatient Certification: To this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation nours after death. neral Director: Aff y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral I 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical ☐ Caminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2. 29b. Signature ap

Registrar

State

30. Name and address of per

ho completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 23A, PT, II, 27, 28A-F, PER, ME, C955, 9-11-14, SM
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Earl William EISSNER 3:38 PM 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 🕱 M 2 🗆 F Min. April 19,1916 Maryland 93 **Director** 214 09 0700 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland 1 Yes 2 No Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 8 Brightwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 X Yes : 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates. 27 is marked other than "natur traumatic event, the M dical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. U. S. Government armed services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Florence Edith Worthington Harry Franklin Eissner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 8 Brightwood Dr., Hagerstown, Maryland 21740 Blanche G. Eissner - wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rose Hill Cemetery 20a, Method of Disposition 20c. Location - City or Town, State 1x Burial 2 ☐ Cremation 3 ☐ Removal from State 10/31/09 Hagerstown, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses Name and Address of Facility MINNICH FUNERAL HOME 21740 Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Des Medical Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed onem that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical to IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> The law requires HIP FRACTURE 1 Yes 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 5 Pending SUBJECT FELL OUT OF BED 1 ☐ Yes 2 X No 2 X Accident 10-25-2009 UNK Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 19800 TRANQUILITY CIR APT 229 HAGERSTOWN, MD. ASSISTED LIVING FACILITY Hospital To the Hospital within 24 hours a To the Funeral E Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier dittle of certified and the first of the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certified and the continued of the cause(s) and manner as stated.

| Certified and the continued of the cause(s) and manner as stated. 29b. Signature and title of certified and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-5+1 Hour 01 d Will 31. Date filed (Month Day Year) 2009 State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records.

of Vital

Division

Dwight Cooliage Eppard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland	/ Department of He	ealth and Mental H	vaiene

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Physicia Medical Examin		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death											
		4a. Facility Name (if not institution, give Washington County Hospit		4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington					
Funeral									4Hrs. 8. Date of	pate of Birth(MM/DD/YYYY) 9. Birthplace (State or			
Director	į	214-84-3147 1X M 2 F 43 Yrs. Months Days Hours Min. 08/1							100	5/1966 Foreign Country)Maryland			
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c City T	our or Loca	tion							10d. Inside City Limits
A .	5	Maryland Washington Hagerstown											1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What 931 Security Road 21742 USA								t Countr	ry?		
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent I Armed Forces?	Ever in U.S.					? (Specify Yes or I uerto Rican, etc.)	No-	14. Race - White,		an Indian, Black,
s after de ral", or i	by Fu		If Yes, Give Year or Dates:	X No	1		X No	<u> </u>			Specify:		iite
24 2	Completed	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	ly highest grade com College (1-4 or 5				Occupation rking life. D		d of work done e retired)	16b. K	ind of Busi	ness/Ind	dustry
5-0036 led within Hygiene. other than	팂	12			Elec	trici					rivat	:e	<u> </u>
	Be	Winifred Eppard Gladys Carr									3urname)		
MD 21 d 2 should lth and Me n 27 is ma	의	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Alexander-Hackney/sister 2806 Alex Court, Bowie, MD 20716											
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,	İ	20a. Method of Disposition 1 K Burial 2 Cremation 3	Removal from Sta	20b. Pla	ace of Dispo ematory or o	sition (Na	me of ceme	-	Date		ocation - 0	City or To	own, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:			Linc	oln (Cemete	ery	11/7/2009	Br	entwo	od,	MD
Salt ermit. Depart mpor njury		21. Signature of Funeral Service Licens	4:01		22.	Name and	Address o	f Facility	Fort Line	oln :	Funer	al I	Home
Physician	-1	23a. Part I. Enter the disease, or compl	ications that caused t	the death D	34 On not enter	01 B]	ladens	burg	Rd., Bre	ntwo	od, M	[D]	20722 Approximate Interval
/Medical		failure. List only one cause on each	ch line. Heroin in				or dynng, sc	ion as card	nac or respiratory e	11031, 31101	SK, OF FICE		Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse										
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
ted ansit	Exan	events resonang in death) Last	Due to (or as a conse	quence of):									
8760, ifficate be executed ng physician and as the burial - transit	n/Medical	X UNPENDED 23a,27,28a-f,perME, g897 11/16/09 TT											
8760, tificate bung physic as the bur	%	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcom	e of pregna	incy			Ectopic pr		23d	l. Date of d	lelivery Da	ıy Year
trithe d		Part II. Other significant conditions		but not resi	ulting in the	underlying	g cause give	en in Part I	. 23e. Dio	tobacco u	use contrib	ute to th	e cause of death?
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ords, w requires s been s should	Completed	autopsy pr										psy findings available mpletion of cause of	
Reco	٥			performed? 1 ✓ Yes 2							ded? death? No 1 Yes 2 No		
Vital Reconstitutes of the continuation of the	8	25. Was case referred to medical examiner?							neck only one)				
Physic rathis	္ပ	1 Yes 2 No	ospital: 1 Inpatier		R/Outpatien			-	lursing Home 5	Resider		Other:	
ion of tending Pheath.		. 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe now injury occurred											
Division of Vital Records, rat or Attending Physician: The law requirens after death. al Director: After this certificate has been sided in by the fineral director, page 2 should be.	Certification	3 Suicide 6 X Could not be determined (Specific) Topics I depression (Specific) Topics I depr							28f. Location or Town Hagers	28f. Location (Street and Number or Rural Route Number, City or Town, State) 931 Security Rd Hagerstown, MD			
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendicompletely filled in by the funeral director, page 2 should be detached for use	edical C	4 Homicide Homicid											
5 × 5 × 5	ĕ⊦	29b. Signature and title of certifier	and manner stated.			29	c. License r	number		29d. D)ate signed	d (Mont	h, Day,Year)
10		Mille Grass	ell MD				O.C.M.	.E.	_	Nove	ember 4	, 2009)
A.			sistant Medical	Examine	er 111 l	Penn St	reet, Bal	timore,	MD 21201				
Sta Registr	te ar	NOV 0 5 2009	32. Registrar	s Signature	park	1							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ctober 25 Physician/ ^{າວ}ີ2009 Lillian Fertik 1:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery <u>Hebrew Home of Greater Washington</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🗓 F March Day 161-03-3932 Philadelphia Pa Director 96 191B Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Directo Md. Montgomery Bethesda 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9631 Alta Vista Terrace 20814 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exar 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Schools Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Secretary Philadelphia Public Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rubin Max Ethel Waldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9631 Alta Vista Terrace, Bethesda, Md. 20814 Marian Richter / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montefiore Cemetery 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 26, 2009 Philadelphia, Pa. 21. Signature of Funeral Service I censee 22. Name and Address of Facility Torchinsky Hehrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 _ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖪 No Month Year Pregnant at time of death 5 Other (specify) led by the a detached f 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, cate has been siç ; page 2 should b 1 🗍 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed: death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar muna

31. Date filed (Month, Day, Year)

OCT 28 2009

farle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 7/2009

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1801

₱32. Registrar's Signature

29c. License number

Jefferson

D0064871

29d. Date signed (Month, Day, Year)

J0825

10/25/09

Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10/25/2009 1:30 p M Helen Emily Frostbutter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Beach Calvert 4495 Willows Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)

WV Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🔀 F Director 577-32-0993 83 07/31/1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Middial Exact in act of the Indiffed at Calvert Chesapeake Beach 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20732 4495 Willows Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item. Elementary/Secondary (0-12) College (1-4or 5+) University of Maryland Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys M. Haney Joseph J. Benistone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4495 Willows Road, Chesapeake Beach, MD 20732 Toni Nelson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/28/2009 Clinton, MD Lee Crematory 21. Signal re Funeral Service License 22. Name and Address of Facility Lee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 Mounts 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ARTERY DISEASE CORONARY disease or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any seding Is immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami sician and burial-tran Due to (or as a consequence of): attending physician for use as the buris Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MYPERTENSION, CHROMIC 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2: autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🕽 📈 б 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed P.O. Box 68760, signed by the a d be detached f Division of Vital Records, has certificate this After th funeral To the Hospital or Attending I hours after death. 'uneral Director: Af ely filled in by the fur the Funeral Directory filled in by within 24

within 72 hours after death with

Baltimore, Maryland 21215-0036

arw) 10

State Registrar

Medical

(Check only one)

29b. Signature and till of certifier

31. Date filed (Month, Day,

29c. License number 50233

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Drive, Suite 310, Prince Frederick, MD 20678

282009

State of Maryland / Department of Health and Mental Hygiene 36108 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22 2009 **Physician** 7:20 P M NADINE GLORIA FLETCHER OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F 60 Months Days Hours Min Director GEORGIA 212-56-0413 4 1948 Usual Residence of Decedent 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-r sn other traumatic event, the medical Examinar must be motified. Director 1 XYes 2 No MD PRINCE GEORGE'S BRENTWOOD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4311 40th PLACE 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. BLACK þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 11th CASHIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN KELLY ၉ ETHEL JACKSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is a any injury or other traul once. VELEDA FLETCHER/DGT 4311 40th PLACE BRENTWOOD, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/2/2009 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEMETERY CHELTENHAM, MARYLAND 21 Signature of Juneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the discusses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects. Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2√√ No autopsy certificate 2X No 1 □ Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 1 Inpatient 5 ☐ Residence 6 ☐ Other_(Specify) nours after death.

neral Director: After this

filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) at phin 4.0 D43440 OCTOBER 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROINTAN FARAHIFAR M.D. 12150 ANNAPOLIS ROAD SUITE B312 GLENDALE, MD 20761 31. Date filed (Month 32. Registrer's Sign State OCT 2 8 2009 Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10/21/2009 Physician/ 2pm [™] Herrick Edward Frost Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1305 Eva Gude Rd. Crownsville Anne Arundel If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2 □ F Country CT (Month 117 1936 Director 043-28-3534 73 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director NV Clark Las Vegas XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 89030 USA 211 N. 8th St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Comodities Broker Financial Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Herrick E. Frost Katharine Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1305\ Eva\ Gude\ Rd.\ Crownsville,\ MD\ 21032$ Lorelei Derian Sister 1305 Eva Gude Rd. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State injury or 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 10/24/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 Oal 12 Ridgely Ave. 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) teriose Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician; The law requires that the death certificate be executed the attending physician and thed for use as the burial-transi Abet that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 1 Yes 2 No cate has been signed by i page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an after death.

Director: After this certificate has! autopsy completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 Gertifying Nurse Practioner To the best of my knowledge, death one diet the time, date and place, and due to the nausols) and manner as state 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Deputy pleted cause of death (Item 23a) (Type, Print) ones mD 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** October 26. 11:57am Dorothy Rachel Glaser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) 12/20/1918 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🕅 F Days Hours 90 132-03-5920 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits r items 23a or 28a-f show insermast be redified at Director 1 ☐ Yes 2 🕅 No Maryland Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 15100 Interlachen Blvd., #903 20906 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married natural", or 1 ☐ Yes 2 X No other traumatic event, the Medical Evan Specify: 3 Ø Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) B'nai B'rith Elementary/Secondary (0-12) College (1-4or 5+) International Program Assistant permit. Pages 1 and 2 should be filled. Department of Health and Mental Hwrlingortant: If item 27 is merany injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Helfant Lillian Secunda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Weiss - Daughter 14912 Clavel Street, Rockville, Maryland 20853 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition King David Memorial 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 10/28/2009 Falls Church, Virginia Gardens 21. Signature of Foneral Service Licer 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 J241 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac trest disease or condition resulting in death) NOUS /Medical Due to (or as a consequence of): Examiner Myocarrial clays Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖳 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Division of Vital Records,

certificate be

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

mpletely

(Check only one)

29b. Signature and title of certifie

Sarmiento Mauro 31. Date filed (Month, Day, Year) OCT 28 2009

140

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

Suburban HOSpitz (8600 old bearfetown Rel.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

46895

29d. Date signed (Month, Day, Year)

10/26/09

Susurban Hoyn, he betreigh

Maria Sabina Gonzalez-Gurierrez Morta Sabina Gonzalez-Gurierrez Morta Sabina Gonzalez-Gurierrez Sa Secus Member (International present statement) Some Morta Sabina Gonzalez-Gurierrez Some Morta Gurierrez (International present statement) Some Morta Sabina Gonzalez-Gurierrez (International present statement) Some Morta Gurierrez (Intern			te.	1 - For State Registrar	State of Maryla		artment of rtificate of			2009	36111
Springbrook Adventist Nursing Center Springbrook Adventist Nursing Ce		/Media	cal	Maria Sabina Gonza	lez-Gutierre	Z	4b. City. Town.	or Location of Deat	Month October	23, 2009	
Use State Doc Cortin Tool Institute Coput Tool Institute Cop		Funeral	ner	Springbrook Advent 5. Social Security Number 6. Se	x 7. Age (In yrs	. last birthday)	Silver	Spring If Under 24 Hrs	8. Date of Birth	Montgomer	y hplace (State or Foreign untry)
The property of the property o		ath with the Maryland 23a or 28a-f show	rai Director	10a. State 10b. County Maryland Montgomer 10e. Street and Number	cy 01		10f. Zip Code		10g	i. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 💆 No untry?
The property of the property o	15-0036	n 72 hours after des *natural', or items	leted by Fune	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	16a. Dece	Yes 2 No	Specify: Sa.	lvadoran	Black, White Specify: Wh	e, etc. ite
Physician Modical Examiner Ph	nd 212	e filed within al Hygiene. I other than went, the M		12	College (1-4or 5+)			,			
Physician Modical Examiner Ph	Maryla	id 2 should the and Ment 27 is market traumatic of	P	19a. Informant's Name/Relationship (T)	vpe, Print)			t and Number or Ri	ural Route Number, C	City or Town, State, 2	
Physician Modical Examiner Ph		Pages 1 an nent of Heal ent: If item 3 ury or other		20a. Method of Disposition 1 Burial 2X Cremation 3 F	20b.	Place of Dispo cemetery, cres	sition (Name of matory or other pla	ace)	Date 20	c. Location - City or	Town, State
Physician (Modical Examiner) The part of	Bait	permit. Departr Imports any ing		Price Mills	M01!	500 9	33 Gist	بلط و. Ave	, Silver S	pring, MD	
Due to (or as a consequence of): Tank, leading to mimediate cause (linearse or injury resulting in death) Last	à	/Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line. a. ANEMIA Due to (or as a conse	quence of):		ing, such as cardia	c or respiratory arrest		Interval Between Onset and Death MONTHS
The second of th		ate be executed thysicien and the burial-transit	Cai	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):	CCIDENT				YEARS
25. Was case referred to medical examiner? Yes 2 No	O. Box	the death certific by the attending p ached for use as	nysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 【XNo	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	aldeath 3□		су			•
25. Was case referred to medical sexaminer? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 ER/Outpatient 3 DOA 28. Date of Injury at Work? 29. Accident 3 Suicide 4 Homicide 29. Place of Injury - At home, farm, street, factory, office 29. License number 29. License number 29. License number 29. Date signed (Month, Day, Year) 29. Signature and title of certifier 29. Signature and difference of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 ER/Outpatient 3 DOA 28. Date of Injury - At home, farm, street, factory, office 28. Place of Injury - At home, farm, street, factory, office 29. License number 29. License number 29. Date signed (Month, Day, Year) D19609 30. Name and address of per on who completed explored the death (Item 23a) (Type, Print) Raman Tuli, M.D., 8100 Connecticut Avenue, Chevy Chase, MD		equires that en signed b ould be deta	by		ntributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.			
The state of the s	al Reco	79 —							autopsy performe	d? prior to death?	completion of cause of
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)	ö	ding Phys n. After this funeral di	၉	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	28b. Time of	f 28c. Inju	ther: 4 \(\frac{1}{\text{M}}\) Nursing Fury at ork?	tome 5 ☐ Residence		cify)
D19609 October 27, 2009 30. Name and address of per on who completed and se of death (Item 23a) (Type, Print) Raman Tuli, M.D., 8100 Connecticut Avenue, Chevy Chase, MD	DIVIS	itel or Atternations after desired birectored in by the		3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spec	ify)			City or Town,	State)	
D19609 October 27, 2009 30. Name and address of per on who completed and se of death (Item 23a) (Type, Print) Raman Tuli, M.D., 8100 Connecticut Avenue, Chevy Chase, MD		the Hosp hin 24 hor the Fune npletely fi	Aedical	(Check only 2 Medical Exami	ner: On the basis of examin	owledge, deatl	vestigation, in my	opinion, death occi	urred at the time, date	and place, and due	to the cause(s)
Raman Tuli, M.D., 8100 Connecticut Avenue, Chevy Chase, MD		with to con	2	1 Kiti	ompleted e e of death (Ita	om 23a) (Tvoe	D1				
Registrar OCT 28 2009 Church S. Jacks	- 5% No.			Raman Tuli, M.D., 31 Date filed (Month, Day, Year)	8100 Connect	icut Av	enue, Ch	evy Chase	e, MD		

			For State Registrar		Marylan				ealth a	and M	ental Hyg	Reg. No.	2009	36112
	Physici /Medic		1. Decedent's Name (First, Middle, Las Terry Goldstein	ST)							October		200 ⁹ gar	7:30A M
	Examir	er	4a. Facility Name (If not institution, give The Hebrew Home C	street and num of Great	er Wasl	ningtor		Town, or ckvi	Location o	of Death			County of Death Montgom	
- **	Funeral Director			ex □M 2 /□F	7. Age (In yrs. 95	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth 1/1/20/14	944	9. Birth	place (State or Foreign Ytry)
M	ref show	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgo	omery	10c. Cit	y, Town or Lo								10d. Inside City Limits 1 Yes 2 No
4	3a or 28	al Direc	10e. Street and Number 6105 Montrose F	Road				Code 2085	2			•	en of What Cou ted Sta	,
036	The many states and 2 should be many within the many and population of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2□ Married 3 ☆ Widowed 4□ Divorced	12. Was Dece Armed For 1Yes If Yes, Giv Year or Da	ces? 2[X]No e		Vas Dece f Yes, spe I □ Yes		spanic Ori in, Mexicar Specify:		ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White, W Specify:	
21215-0036	piene. r than "natu the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-	-4or 5+)	16a. Deced (Give life. L Typis	kind of wo	al Occupa ork done d se retired	ation during mos)	t of worki	ng		d of Business/Ir	•
Maryland 2	Mental Hyg Rarked other Ratic event, i	To Be C	17. Father's Name (First, Middle, Last) Morris Lessinger	•					Sad	ie"u	(First, Middle,			
, Mar	ealth and n 27 Is m		19a. Informant's Name/Relationship (Marcie Goldstein			3709	Sou	th G	eorge	er or Rura Mas	on Driv	e Fa	Town, State, Zi	rch VA 2041
Baltimore,	nent of He nt: If iten iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specif	Removal from S	state	Place of Dispo cemetery, cren Lebano					5/2009		ation - City or T	
Balti	Departr Importa any inju		21. Signature of Funeral Service Licer	isee	Moll				s of Facili	ty			apels I	
	hysician /Medical		23a. Part1. Enter the lisease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	_aP	neumon	ia	er the mo	de of dyin	g, such as	cardiac (or respiratory ar	rest,		Approximate Interval Between Onset and Death
	xaminer	76	Sequentially list conditions,	bA	or as a consec 1zheim or as a consec	er's De	ement	ia						
8760,	hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	quence of):								
P.O. Box 68	after d for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown		irth 2 ☐ Feta ant at time of o	aldeath 3	Ectopic p					2	3d. Date of deliv	very Day Year
	signed b	l by Pl	Part II. Other significant conditions of Chronic Kidney	•		sulting in the ur	nderlying	cause giv	en in Part I	l.	23e. Did to			the cause of death?
Rec	te has been age 2 shoul	Completed by	Anemia								24a. Was a autop perfor	sy rmed?	24b. Were aut prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
/ital	ertifica ctor, p	Be C	25. Was case referred to medical examiner?							of Deatl	(Check only o		12,103	- A. III
or Vita	this o	ဥ	1 Yes 2 No 27. Manner of Death	Hospital: 1 🔲 II	·	ER/Outpatien			7		me 5 ☐ Resid		Other (Spec	ify)
Division or Vital	eath. Ior; After the funer	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Mont	h, Day Year)	Injury	М		Yes 2	No				
Divi	rs after d al Direct	Certifi	4 Homicide determined	buildir	ng, etc. (Speci						City or Tow	vn, State)		al Route Number,
Dir	within 24 hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2.	Medical Certification:	29a. Certifier (Check only one)		sis of examina		vestigatio	n, in my c	pinion, de					
1.	To the company	Ň	29b. Signature and title of certifier	-Duj	to wa	>	29	D57				29d. Date	signed (Month	Day, Year)
y			30. Name and address of person who Damion Doyle MD 1					t Ro	ckvi1	le M	D 20852		1	
- A ₂ -	Sta Begisti		31. Date filed (Month, Day, Year)	32 R	egistrar's Sign	ature _	16.0	ı						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** Dorothy 6 Lassie 23 2:55 2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Director 579-42-4568 Dec. 31, Maryland Usual Residence of Decedent 33/09 T.O. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7407 Willow Road 21702 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. 12 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burgess Dodson Dollie Hilderbrand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donald Dodson / Brother Middletown, Maryland 21769 2 Rhoderick Circle Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October Glassie 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory 26, 2009 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 **Physician** /Medical pertension **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 9 28a. Date of Injury (Month, Day Year) 28b. Time of Injury To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier D0055061 October 23, 2009 & MD who completed cause of death (Item 23a) (Type, Print)
NAGY 300 WEST NINTH ST; FREDERICK, MD 21701 30. Name and address of person J. NAGY

State

Registrar

31. Date filed (Month, Day, Year)

parke

32. Registra s Signature

Cenera

2009 ▶

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
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Registrar DHMH 17 Rev 1/2001

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4 Homicide

(Check only one)

ASHVIN J

31. Date filed (Month, Day

29b. Signature and title of certifier

Pate

determined

an 6

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

102 Paul Mellon Ct Suite 102 Waldorf, Md. 20602

29d. Date signed (Month, Day, Year)

NOVEMBER 04 2009

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral L

BA 3

State Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medical

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

32. Begistrar's Signature

BARAL, MID

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

0-13-2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12:50 AM Hammers1a October 28, 2009 Theodore James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 16919 Alcott Road Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 218-30-7581 74 25, Director Oct. 1935 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Exyminar insering the notified at 1 ☐ Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16919 Alcott Road U.S.A. 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. KYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ If Yes, Give Year or Dates: Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Spray Painter Automotive 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Edward Hammersla Helen Clementine Daly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hammersla/Son 16919 Alcott Road, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 10/30/2009 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or residually arresshock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ARDI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D0026523 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dino J. Delaportes MD 11110 Medical Campus RD. Hagerstown MD 21742 31. Date filed (Month, Day, Year) 0 CT 3 0 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma	-	Certificate			,	•	2009	36117
	Physici	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month		y Year	3. Time of Death
	/Medic		Leatrice Joy I						Octobe			3:00 A ^M
	Examin	er	4a. Facility Name (If not institution		n# 2 A			Location of Death			County of Death	
an phil	Francis		15300 Pine Orcl		e (In yrs. last birt			Spring If Under 24 Hrs.	8. Date of Bir		ntgomery	place (State or Foreign
	Funeral Director		579-16-4906	1 □ M 2 1 F		Yrs. Months	Days	Hours Min.	8. Date of Bir (Month, Di 12/09/	1922	IÎÎ	intry) inois
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryla f sho	ō	MD Montgo	omery	Silver							1 K∐Yes 2 □ No
	r 28a-	rect	10e. Street and Number	-		10f. Zip	Code			10g. Cit	izen of What Cou	intry?
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show afte event, Inchedical Evan har in the notified at	Funeral Director	15300 Pine Orcha	ard Drive Ap	t. 3A	209	06		Ţ	Jnite	ed State	S
	tems	nue	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Decede If Yes, speci	ent of His fy Cuban	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White,	
35	rs afte	by F	1 TNever Married 2 Marr 3 Widowed 4 Divorced	ied 1 ∏Yes 2 📆1 If Yes, Give Year or Dates:	No	1 □Yes 2	Mo	Specify:			SpecifyWhit	e
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7	15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Const.											
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yland	d be fi ental F red of c eve	Be C	John H. Harpst	•				Blanche	•		Surriame)	
<u> </u>	2 should be and Mental is marked craumatic ev	은	19a. Informant's Name/Relations		19b.	Mailing Address	(Street a				or Town, State, Zi	ip Code)
Z N	alth a alth a 27 is		Pamela Groves /			2 Rockwa						,
e G	es 1 a of He of He fitem	1	20a. Method of Disposition	-	20b. Place of cemeter	Disposition (Namy, crematory or other	e of her place)	Date	20c. Lo	ocation - City or T	own, State
Ē	. Pag tment tant: I jury o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1	icoln Cem	neter	ry 10/28			ntwood,	
baltimore,	permit. Pages 1 and 2 should be Department of Health and Mentis Important: If item 27 is marked any injury or other traumatic enonce.		21. Signature of Funeral Service	Licensee	1			s of Facility Jos nsin Ave	-			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that aused	the death. Do r	ı				`		Approximate Interval Between
May 1	Physician	i	Immediate Cause (Final			ctive Pu	1mon	ary Dise	ase		2	Opset and Death Years
A. P. Cont.	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	of):						
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	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events					ļ				
,	rtificate be executed ng physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):							
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DOX DOX	death atter for u	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🏝 No		2 Fetal death	3 Ectopic pro	egnancy ec <i>ify)</i>			1	23d. Date of deliv Month	Day Year
). O	tt the o	hysi	9 Unknown	9 🗆 Unknown								
<u>,</u>	sician: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use.		Part II. Other significant condition	-	_		_					the cause of death?
5	requii	eted	Hypertension,	Dementia, Ke	current	urinary	Ira	Ct	1 🗆	Yes 2		bably 4X Unknown
records,	le law has t	Completed by	Infection.						24a. Was auto		24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
[a (a	in: Tł ificate or, paę	ပ္ပ	25. Was case referred to medical					00 Plant (Part	1 □Yes	2 XNo	1 ☐Yes	2 No
>	/sicia s cert directe	8	examiner?	Hospital:	ent 2□ER/Out	tpatient 3 DO	Othor	26. Place of Deat			6 □Other (Spec	(6.1
5	Attending Physician: The ser death. rector: After this certificate he by the funeral director, page	on: To	27. Manner of Death	28a. Date of Inju	rv 28b. T		Bc. Injury Work?		28d. Describe			ny)
VISION	tendir eath. or: Ai the fu	catic	2 Accident investig	ation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M		es 2□No				
	al or Att after d Direct d in by	Certification:	3 □ Suicide 6 □ Could r 4 □ Homicide determ		ury - At home, far c. <i>(Specify)</i>	m, street, factory,	office		28f. Location (City or To	Street an wn, State	nd Number or Run e)	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 24 hours after death. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Medical C		g Physician: To the best Examiner: On the basis o and manner sta	f examination and							
:	within 50 th	ğ	29b Signature and title of certifier	1	*		License				te signed (Month,	Day, Year)
	20		Works	Xougsta	ORKE) DO	0121	Z I		10/2	1/2009	
			30. Name and address of person	(/					2225			
	Sta	to.	George F. Sengs 31. Date filed (Month, Day, Year)				Whea	ton, MD	20906			
	Star Registra		OCT 28 20	ng Record	ar's Signature	alle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 121 26,2009 ons October 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick, MD Calvert Calvert Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 7, 1942 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 □ M 2 🗓 F 67 220-40-3632 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 💟 No MD Calvert Huntingtown 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 1120 Ponds Wood 20639 Road USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public Schools 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E1mer Ray Lettie Fletcher 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4504 Dalrymple Rd. Chesapeake <u>B</u>each,MD20732 Clinton Brown/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State nonds UMC 10/30/09 Chesapeake Bch., MD 22. Name and Address of Facility Sewell Funeral Home Edmonds UMC f Funeral Service Licensee 1451 Dares Beach Rd. Prince Fred.,MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) endometria JACVE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury

the death certificate be executed burial-trar P.O. Box 68760. physician the as attending the þ Division or Vital Records. has certificate this After death.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Funeral

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7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

within

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event

Physician

/Medical

Examiner

3altimore, Maryland 21215-0036

Certification: 1 Natural 5 Pending investigation Hospital or Attendl 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifle 29d. Date signed (Month, Day, Year) D0061283 Name and address of person w

JW)

State

31. Date filed (Month, Day

262009

			For State Registrar	Certificate of Death	and Mental Hygiene Reg. No. 2009 36119
il.	Division		Decedent's Name (First, Middle, Last)		Date of Death 3. Time of Death
Ag.	Physici /Medio		FLOYD M HEIGHT SIR		OCT 24 2009 12 45 AM
al	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	
	Funeral			yrs. last birthday) If Under 1 Year If Under	24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		216-22-1487 ¹\(\overline{x}\) [™] 2□F	82 Yrs. Months Days Hours	Min. (Month, Day, Year) Country) May 16, 1927 Mary land
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location	10d. Inside City Limits
	a-f sh	ctor	MD Calvert S	St. Leonard	1 □Yes 2√ No
	ith the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	eath v	Funeral	6319 Mackall Road 11. Marital Status 12. Was Decedent Ever i	20685	USA gin? (Specify Yes or No- 14. Race - American Indian,
ယ္	after d or iter niner	Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give X	If Yes, specify Cuban, Mexical	i, Puerto Rican, etc.) Black, White, etc.
5-0036	ural", c	d by	3 M widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: Black
215-	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	t of working
212	d with giene. er thar	om (Elementary/Secondary (0-12) College (1-4or 5+) 4	Oyster Shucker	Restaurant
	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mothe	er's Name (First, Middle, Maiden Surname)
Maryland	should be filed within and Mental Hygiene. s marked other than "sumatic event, the Med	은	George Height 19a. Informant's Name/Relationship (Type. Print)		ssie Johnson er or Rural Route Number, City or Town, State, Zip Code)
	1 and 2 sho Health and em 27 is me		Beverly Brooks/Daughter		. St. Leonard, MD 20685
Baltimore,	S = = 0			b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
ij	E Pages treent of trant: If ite			rooks UMC Cemetery	10/30/09 St. Leonard,MD y Sewell Funeral Home
Bal	permit. Page Department of Important: If any injury or once,		21. Signitur of/Funeral Septice Libensee		
			23a. Part. Enter the disease or complications that caused the control shock, or heart failure. List only one cause on each line.		each Rd Prince Fred., MD20678 cardiac or respiratory arrest, Approximate Interval Between
	Physician	7.1	Immediate Cause (Final disease or condition	Janha	Onset and Death
*	/Medical Examiner		resulting in death) Due to (or as a con	sequence of):	
	27 60 17	e.	Sequentially list conditions, If any, leading to immediate Due to lorge a such		
	cuted nd ransit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	beter Millitur	
90,	icate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a con	sequence of):	
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Box (death certifica attending pharmage of for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pre		23d. Date of delivery
	e deatl he atte	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		Month Day Year
P.0	res that the de signed by the a be detached t	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I	. 23e. Did tobacco use contribute to the cause of death?
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000	aw requir is been s 2 should	Completed			24a. Was an 24b. Were autopsy findings available
		E			autopsy prior to completion of cause of death? 1 \(\section \) yes 2 \(\section \) 1 \(\section \) yes 2
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>	ician: The certificate ha	Be	25. Was case referred to medical examiner?	Other	of Death (Check only one)
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DHMH 17 Rev 1/2001

Glenn Eugene H		nd State of Maryland / Department of Certificate of Certificate	_	ygiene
Physici		Registrar 1. Decedent's Name (First, Middle, Last)	Death	Reg. No. 2000 36 20 20 20 20 20 20 20 20 20 20 20 20 20
Medical Exami		Glenn Eugene Holland		Month Day Year 1333 hrs
		4a. Facility Name (if not institution, give street and number) Calvert Memorial	4b. City, Town, or Location of Death Prince Frederick	4c. County of Death Calvert
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		218-94-2412 1XM 2 F 46 Yrs	Months Days Hours Min.	Foreign Country) MD
, h		Usual Residence of Decedent		10d. Inside City Limits
_ OW An		MD Calvert Sunder		1 Yes 2 X No
daryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.		6828 Kent Road	20689	USA
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		as Decedent of Hispanic Origin? (Sp 'es, specify Cuban, Mexican, Puerto	
ter dea		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year	Yes 2 X No specify:	_{Specify:} Black
ours af atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Deceder	nt's Usual Occupation (Give kind of v	
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5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First, Middle, Last)		Newspaper (First, Middle, Maiden Surname)
215 be file ntal Hy rked o	Be	Leroy O. Holland	Martha	
D 21 should I and Mer	P			Rural Route Number, City or Town, State, Zip Code)
md 2 sho and 2 sho tealth and tem 27 is traumati		20s Mothed of Disposition 20h Place of Dispos	sition (Name of cometery	nderland, MD 20689 Date 20c. Location - City or Town, State
nore ages 1 nt of H nt: If i		1 X Burial 2 Cremation 3 Removal from State St. F. Cremation of St. Edition of St.	dsuMC Cem. 10	/29/09 Chesapeake Bch.,MD
Baltimore, sernit. Pages 1 at Department of Hes Important: If ite		4 Donation 5 Other Specify:		ewell Funeral Home
		Joshanfer Stevel 12	51 Dares Bch.	Rd. Prince Fred.,MD20678
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac c	or respiratory arrest, shock, or heart Approximate interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):		
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	nine	if any, leading to immediate cause. Enter Underlying Cause		
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tal Reco cian: The law certificate has ector, page 2 s		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 No 1 Yes 2 No
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Division Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	ırtifi	Suicide Could not be determined (Specify) Major Board / Highway		or Town, State) Rt. 2 and Kent Road, Sunderland, MD
Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate the Tathours after death. the inversal Directors: After this certificate has been signed by the attending phys upletely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	urred at the time, date and place, and	d due to the cause(s) and manner as stated.
To the Hosy within 24 ho To the Fun-	Medical	one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	ation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 25, 2009
		30. Name and address of person who completed cause of death (Item 23a)	U.O.IVI.E.	05(050) 20, 2000
dew 4			Penn Street, Baltimore, MD	21201
S	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature 32. Registrar's Signature 33.	ales	
Regis	trar	UC 28 2009 Clevera p. 490	y == -	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Irene Mary Fowler Hopkins October 0 24 2009 4:27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days Hours Yrs. 579-10-6339 Director 87 01-01-1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Examiner must be recitized at aprice. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔯 No Funeral Director Anne Arundel Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 265 Sansbury Road 20758 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 🗓 No Specify: Specify 3 X Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Edward ൧ Fowler, Helen Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine I. Hopkins, daughter 307 Ludlow Road, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. James Cemetery 10-28-2009 Lothian, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20736 NOY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final Physician Par resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 24a. Was an autopsy performed? Yes 2 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place, and due to the cause(s) and place. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, who completed cal death (Item 23a) (Type, Print) 25 01 al 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar 2009

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		For State	State of Marylan				i Mental Hy	giene	000	26122
		Registrar		<i>Ce</i>	ertificat	e of Death			009	36122
Physicia	an	Decedent's Name (First, Middle, Last		14	[1.		2. Date of De Month	Day	Year	3. Time of Death
/Medic		Clark	Villiam	110	phis		Octob	or Z	3 200	9 19:25fm
Examin	er	4a. Facility Name (If not institution, give	11 \	11	- 3	Town, or Location of Dea	14	4c.	County of Deat	th
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Funeral		5. Social Security Number 6. Se	7 M 2 D E) If Unde Months	1 Year If Under 24 Hi Days Hours Mil	Month D	ay, Year)	Co	hplace (State or Foreign
Director		012-40-1500	60) 118.			Feb 4,	1949	Rho	de Island
and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation					10d, Inside City Limits
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ırs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes	2 X No Specify:			Specify: Wh	ite
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ald be dents rked ric e	ام	Eugene E. Hand				Marcia	Louise B	ates		
shou and h	_	19a. Informant's Name/Relationship (7)	rpe. Print)	19b. Mail	ing Address	(Street and Number or I	Rural Route Numb	er, City or	Town, State, 2	Zip Code)
alth a		Monica J. Maxon/wi	ife	9400	Thor	hill Rd. Si	lver Spr	ing,	MD 209	01
item item		20a. Method of Disposition	20b. F	Place of Disp emetery, cre	osition (Na	ne of	Date	20c. Loc	cation - City or	Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it which is Examinating the notified at once.		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				Crematory 1	0/26/09	Wood	dbine, 1	MD
mit.		21. Signature of Funeral Aervice Licens				d Address of Facility ti			·	
Pa m m o		Devely L t	Feel to 1251	B	everl	L. Heckrot	-+α Β Δ 	ຕາລາ	rkevill	x 704 a MD 21029
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or								Approximate
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Examiner			Due to (or as a conseq.	derice oi).						
	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
cuted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events								
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h cer endir use	ᅙ	Zob. Was decedent pregnant	3c. If yes, outcome of pregna					2	3d. Date of del	ivery
deat le att	Si	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		□ Ectopic p □ Other <i>(s</i> p				Month	Day Year
tt the by th tache	Physician/Med	9 Unknown	9 Unknown							
s tha	by P	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the t	underlying o	ause given in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
quire en siç uld b	- B						1 🗆	Yes 2	No 3□ Pr	robably 4 🗌 Unknown
aw re	Completed						24a. Was		24b. Were au	topsy findings available
The la	E							rmed?	death?	completion of cause of
an: tiffica for, p	Be	25. Was case referred to medical				26 Place of De	1 A Yes eath (Check only o	2 No	1 □Yes	2 No
ysicl is cel		examiner? 1 ☐ Yes 2 No	lospital: 1 Inpatient 2 🗆	EB/Outpatie	ent 3□ D0		Home 5 ☐ Resi		Other (Spe	cifu)
g Ph er th	Certification: To	27. Manner of Death	28a. Date of Injury	28b. Time of		8c. Injury at	28d. Describe			uiy)
ndin ath. r: Aft e fun	랿	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	Injury	м	Work? 1 □Yes 2 □No				
Atte	iji (i	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho	me, farm, st	treet, factory	, office			Number or Ru	ıral Route Number,
al or s afte	ert	4 Hornicide	building, etc. (Specif	<i>y)</i>			City or To	wn, State)		
ospit houn mera ly fille		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge, dea	th occurred	at the time, date and pla	ce, and due to the	cause(s)	and manner as	s stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exami one)	ner: On the basis of examina and manner stated.	tion and/or i	nvestigation	, in my opinion, death oc	curred at the time,	date and	place, and due	to the cause(s)
To til withi To til comp	ž	29b. Signature and title of certifier		>	290	. License number		29d. Date	signed (Month	h, Day, Year)
		1		111	1)	E2-000		oct	oter:	23,2007
10		39. Name and address of person who co	empleted cause of death (Item	23a) (Type,	, Print)	1 100			-	/
	4	Jonathan Duk	es, M.D. 60	ON		fe St. Ba	16 more	M	10 71	287
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Registra	ar I	UU 28 70	19 /2	B A	n. del	*				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 00 13000 O Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arunde1 5. Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Hours Manth, Bry3 Year 934 Maryland 213-28-9203 Director 75 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified Marvland Anne Arundel 1 Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 513 Fourth St. 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1X Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: B1ack Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Maryland Department Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Toll Facility Collector Transportation 12th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LaFayette Perry Amy V. Hutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyron Hutton(Nephew) 1970 Forest Dr. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place
Metro Crematory 1 D Burial 2 XCremation 3 D Removal from State 10-24-09 Baltimore, Md. 4 Donation 5 Other (Specify) A Manne Roal Sept Sain Sons Mortuary, Signature of Funeral Service Licensee P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Interval Between Onset and Death Physician/ SOM Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 4 Pregnant g Unknown Other (specify) Pregnant at time of death Month Day Year signed by the a d be detached for Yes 2 No 9 Unknown Part II. **Other signifi⊏ant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed' 1 🗆 Yes 2 📈 o 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ NOIDIG 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at work? _1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Sulcide 6 Could not be ☐ Suiciue ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year, 1221 065272 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 RU Jule 300 BAMPINE MO 2040

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DET 26 2009

DU

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36124 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Holland** November 1°, 2009° ar Charles 7:55 PM M L. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick **Examiner** 4b. City, Town, or Location of Death Northampton Manor Health Care Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland Funeral 8. Date of Birth 1 🕅 M 2 🗆 F Hours 0772911917 Director 217-10-9121 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10d. Inside City Limits Frederick Frederick 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8512-A Yellow Springs Rd. 21702 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify. Completed 3 Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) salesman wholesale Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles R. Holland Mida Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Holland/ Middletown, Lombardy Drive, MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Μt Olivet Cem. 11/6/2009 Frederick, MD Signature of Funeral Service Licensee Reeney and Bastord PA Funeral Home MO1222 Church St., Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) pacumenia Medical Due to (or as a co sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Dusito (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I Dayler 2 500 autopsy performed? Yes 2 N 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2X No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at wo<u>rk</u>? 28d. Describe how injury occurred iniury 1X Natural 5 Pending Accident 1 Yes 2 No Investigation 24 hours after death Funeral Director. filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only of 29b. Signa 29d. Date signed (Month, Day, Year) D0051643 November 2, 2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702

)D DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTUBER Joseph O. Hansen, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 X M 2 □ F 577-60-9155 Maryland Director 63 1946 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County d other than "natural", or items 23a or 28a-f show event, it a Medical Evanting must be notified at 1 ☐ Yes 2 K No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21060 715 Raven Green Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No White Baltimore, Maryland 21215-0036 1 □Yes 2**X** No þ 3 Widowed 4 Divorced 1966-69 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UPS Driver and Mental Hyginis marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Lake Joseph O. Hansen, Sr. ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any Injury or other trau 20716 1704 Plymouth Ct. Bowie, MD Kathleen Hansen / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery | 10/27/2009 | Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. lun Approximate
Interval Between
Onset and Death
September 7 23a. Part I. Enter the di case, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fir ure. List only one cause on each line. Immediate Cause (Fil al **Physician** Cerebrovascula disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-trar Due to (or as a consequence of): Box 68760. physician certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year P.O. I signed by the a 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State

HANSEN, JOSEPH

TO PHYSIEIAN :

KNOWN

31. Date filed (Month, Day, Year)

VAMHCS- Perry Point, MD incenta giminarco, Do Registrar's Signatu

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

40054434

29d. Date signed (Month, Day, Year) Octobe 19,2009

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examinar must be refitted at once.
	Physician /Medical Examiner
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

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Funeral Director		5. Social Security No. 212–14–74	415	Sex 1□ M 2 ∑		e (In yrs. I 88	last birthd Yrs	Month	der 1 Year ns Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Oct. 1	irth Day, Year) 5, 1 92	21	Count	ace (State or Foreign try) Land
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification: To Be Completed by Physician/Medical Certification of the completed by th	yalcıdırıyı	IF FEMALE: 23b. Was decedent in the past 12; 1 □ Yes 2 9 □ Unknown	months?	1	s, outcome o Live birth Pregnant at Unknown	2 🗀 Fetal	death	3 Ectopi 5 Other	c pregnanc (specify)	у			2	23d. Date Mont		ry Day Year
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this cer al direct		examiner?	No	Hospital:	1 🔲 Inpatie	nt 2	ER/Outpa	atient 3 🗆	DOA Othe	er: 4 🗆 Nu	ursing Ho	me 5 ☐ Res	sidence 6	Other	(Specify	•)
fter th		27. Manner of Death 1 Matural	5 ☐ Pending		Date of Injur (Month, Day		28b. Time Injur		28c. Injury Work			28d. Describe				·
the fu	3	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not b					М	10	Yes 2	No					
after death. Director: After J in by the funera		4 ☐ Homicide	determined	28e.	Place of Inju building, etc.	ry - At ho . (Specify	me, farm,	, street, fact	ory, office				(Street and own, State)		or Rural	Route Number,
hours a) -	29a. Certifier (Check only	1 Certifying PI 2 Medical Exa	nysician:	To the best of	of my know	wledge, de	eath occurr	ed at the tir	ne, date ar	nd place,	and due to th	e cause(s)	and man	ner as st	ated.
ithin 24 hou the Fune ampletely fi	-	one)		and	manner stat	ted.					atti occui	red at the time				
	-	29b. Signature and t						2	29c. License					1	4	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** INDER KAUR JUNEJA 27, 2009 OCT. 1:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FAIRLAND NURSING HOME MONTGOMERY SILVER SPRING 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛣 F Days Director 104-62-0539 20, 1931 PAKISTAN Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD. MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 3113 FAIRLAND RD. 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. ASIAN INDIAN þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other tha any Injury or other traumotts. HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARNAM SINGH ပ JASWANT KAUR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARPAL SINGH/SON 3113 FAIRLAND RD., SILVER SPRING, MD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 10-27-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM.P.A 1-21 Chambers M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALZHEIMER'S DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending properties of a second IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 724 hours after death. Funeral Director: After this certifica stelly filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 💢 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ္ D52261 OCT. 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1517 HUGO CIR., SILVER SPRING, MD. 20906 ALAN R. SEGAL, M.D. 31. Date filed (Month, Day, Year) 3 Registrar's Signature State 28 2009 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Wesley Jones October 21, 2009 11:25 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**⊠**M 2□ F Director 85 June 2, 1924 MD 216-18-5696 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show Director 1 ☐ Yes 2 No Calvert MD Huntingtown 10e Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 4435 Solomons Island Road N 20639 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Yes 2 f Yes, Give 2 No 1944 -1 Never Married 2 Married Maryland 21215-0036 5 1 ☐Yes 2 No Specify. \$ 3 Widowed 4 Divorced Year or Dates: 1946 Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 School Bus Contractor Transportation other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harrison Jones Louise Chase 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Health a 4435 Solomons Island Road N, Huntingtown, MD 20639 Disposition (Name of Date 20c. Location - City or Town, State Vivian Jones - wife **Baltimore**, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 9 4 ☐ Donation 5 ☐ Other (Specify) Patuxent UMC Cemetery October 26, 2009 Huntingtown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sewell Funeral Home, P.A. Glades a. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** STAGE a. END ALZHEIMERI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any course underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Prostate la that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. CKD IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 □Yes 2 No 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation ours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DG 7814 lew lot 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29449 CHARLOTTE 31. Date filed (Month, Day, Year) FRANCISCA BRUNEY, HALL 20622 CHARLOTTE MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 22 200⁹ 01:10 Audrey Fraze Jennings Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 138–28–7031 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 F Hours Min. New York o#/#5/4937 Director 72 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director Annapolis Maryland Anne Arundel 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 802 Coxswain Way, Unit 103 21401 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2X☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 🔃 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Fraze Anna Cornehlsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas A. Jennings/Son 119 Creekside Drive, Dagsboro, DE 19939 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Kalas Crematory 4 Donation 5 Other (Specify) 10/22/2009 | Edgewater, Maryland 22. Name and Address of FacilityGeorge P. Kalas Funeral Home Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to inimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 perform 2 🗌 No 1 \square Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Hospice 1 🗌 Yes Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Tes 2 No within 24 hours after death

To the Funeral Director: A
completed filled in by the fi Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 200

DHMH 17 Rev 7/2009

State Registrar pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh 9897 11-17-09 vt
State of Maryland 7 Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** anette Kirchner 20 345 M 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Arundel Medical Center Annapolis ,MD Anne Anndel Anne 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1911 **Funeral** Country) MD 1 □ M 2√2√ 98 Director 214-44-4123 Usual Residence of Decedent the Maryland 10h County 10d. Inside City Limits 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Expanner must be retified at 1 ☐ Yes 2√ No Funeral Director MD Anne Arundel West River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Innert of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or in yor other traumatic event, the Medical Examinor must be not or other traumatic event. 5249 Chalk Point Rd. 20778 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2, No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 🍇 🗽 No Specify. White Specify: 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Jenkins Effie Rodgers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6010 Jurney Place LaPlata, MD 20646 Pam Jurney Grandaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quaker Cemetery 10/23/2009 Galesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. Dati 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prevmonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ~7 days Sepsis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 KNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 200 No 3 Probably 4 Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 2 **N**O 1 ☐ Yes 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2.2XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ch D69566 10/20/09

Registrar

State

1 Annapolis

Ivelisse Michel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Parkway

egistrar's Signature

Medical

Year

31. Date filed (Month, Day,

2 Date of Death

		Examin	
ł	F D	uneral irector	
laryland 21215-0036	2 should be filed within 72 hours after death with the Maryland	is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	

1 Decedent's Name (First Middle Last)

Physician OCTOBER 2009 KINDER, SR. **JAMES** ROBERT 8:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery 6001 Muncaster Mill Road-Casey House Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nanth | April 27 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1**X** M 2□ F 72 217-32-4382 Maryland 1937 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Rockville Funeral Director Montgomery 1 XYes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20850 212 North Horners Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 ☐ Never Married 2 Married White Be Completed by 1 ☐ Yes 2 🗷 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stone Mason Concrete 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, John R. Kinder Viola Ricketts ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau 212 North Horners Lane, Rockville, Md. Baltimore, M Mary E. Kinder / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ricketts Cemetery 10/26/09 Derwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signiture of Funeral Service Licenses Name and Address of Facility
Muriel H. Barber Funeral Home m-00470 P. O. Box 5038, Laytonsville, Md. 20882 Morba 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Endstage Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Pulmonary Hypertension cruenticilly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Cor Pulmonale Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Tyes 2 No 3 Probably 4 StUnknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? Yes 2 No page certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No After this certification of the funeral director, p Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending 24 hours after death.

Le Funeral Director; A pletely filled in by the fu death. 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the P within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number J. Kouerchou, MD D 63743 October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Md. 20855 Jocelyne Kouatchou, M.D. 20032. Registrar's Signature 31. Date filed (Month, D State Registrar Darke

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician John Paul Loomis 2009 &307 ™ /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO 34/1564 MEDICAL ININSULA 19/0WAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 10/25/1927 **Funeral** Months Days 1 □ M 2 □ F 81 578-34-8546 Director Washington D.C Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County should be filed within 72 hours after death with the Marylan and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Macilical Examinar must be notified at 1 ☐ Yes 2 No Director MD Ocean Pines Worcester 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 81 Wood Duck Dr. 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No 2 Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Special Agent FBI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Lynn Taylor Loomis Lucile Metzeroth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Loomis / wife 81 Wood Duck Dr., Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/2009 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Lice 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 2ula Part. Enter Me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHF Sequentially list conditions, if any, leading to immediate cause Enter In. Thin Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed ASCVD burial-trans and Due to (or as a consequence of): physician Physician/Medical the use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, page 2 performe certificate l 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records, Physician: spital or Attending P nours after death. neral Director: After t filled in by the funera To the Hospital within 24 hours a

Maryland 21215-0036

Saltimore,

Box 68760.

P.0.

BA8+1

State Registrar

DUNNAR 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of ertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E CARNULL St. SAlisburg Md 21801 MD 32. Registrar's Signature

rucci

09-08191 Mandy Leigh May Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	Reg.	No. 200	9 3613				
Physici edical Exami		Mandy Leigh May	Date of Death Month D October 21,		3. Time of Death 2024 hrs				
		4a. Facility Name (if not institution, give street and number) Route 40 Lavale Red Hill 1/1/2 Mile West of Lavale Lavale Lavale	Allegany						
Funeral Director			8. Date of Birth (Col	hplace (State or Foreign intry) ryland				
ith the Maryland s 23a or 28a-f show any notified at once.	ctor	Usual Residence of Decedent 10a. State	I 10a.	Citizen of What Cour	10d. Inside City Limits 1 XYes 2 No				
th the Ma 23a or 28 notified a	I Director	15617 Mt. Savage Road, N.W. 21545		U.S.A.					
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Datas: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Yes 2 No 12. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	14. Race - Americ White, etc. Specify: Whi	te				
136 thin 72 hours ne. than "natus	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	d)	6b. Kind of Business/li homemake					
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	Charles McMillan Beverly	Carte	r					
alth Z	To	Beverly Carter mother 1561/ Mt.Savage Rd	l.,Mt.		MD 21545				
nor Pages ant of othe		1 XBurial 2 Cremation 3 Removal from State Frostburg Memorial 10/2	26/09	Frostbur	g, MD				
_ ====	į	21. Signature of Funeral Service Licensee 22. Name and Address of Facility During Street Ave., F	rostbu	irg, MD 2	e, P.A. 1532 Approximate Interval				
Physician /Medical *xaminer	ical failure. List only one cause on each line.								
	miner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
cuted nd transit	Exa	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.							
760, ficate be executed g physician and the burial - transit	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	<u> </u>				
Box 687 e death certifice the attending p ed for use as th	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant of the past 12 months? 1 Pregnant at time of death 5 Other (Specify) 9 Unknown	cy	Month [Day Year				
s, P.O. I irres that the signed by the	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to					
Division of Vital Records, P.O. Box 68 Hospial or Attending Physician: The law requires that the death certificate hours after death. Funeral Director: After this certificate has been signed by the attending lely filled in by the funeral director, page 2 should be detached for use as	Completed		24a. Was an autopsy perform 1 ✓ Yes 2	prior to death?	ontopsy findings available completion of cause of 2 No				
ital Recision: The sector, page	Be (25. Was case referred to medical 26. Place of Death (Check or examiner?		esidence 6 🗸 Othe	r: Saana				
of Vital Physical Cities of the control of the cont	- 10	1 Yes 2 No Patent 2 ENOUPAGE 3 DOA 1 Injury at Work? 2 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2		w injury occurred	r: Scene				
ion c tending eath. for: Af the fun	ation	1 Natural 5 Pending Oct 21, 2009 2017 hrs 1 Yes 2 No	Priver auto au	uto collision					
Division spital or Attendir hours after death. neral Director: /	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 4 Homicide (Spec/fy) Interstate/Express	28f. Location (Str or Town, Sta Route 40 Lavale	eet and Number or Rute) e Red Hill 1/1/2 mile	ral Route Number, City e West, Lavale , MD				
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	the time, date ar	nd place, and due to th	ne cause(s)				
20	2	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo October 22, 200					
per		30. Name and address of person who completed cause of death (Itel a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212							
St Regis	ate trar	31. Date filed (Month, Day Year) OCT 2 6 2009 Aurum 3. Aparts							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 27 2009 ear **Physician** 10:20 P M Theodore Franklin McKean /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 300 Northern Ave. Apt. 8A Hagerstown Washington County If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Nov • 29 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 **∏** M 2 □ F 1921 Pennsylvania 217-10-2968 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any illury or other traumatic events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 300 Northern Ave. Apt. 8A 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ½Yes 2 □ No If Yes, Give 1941 – Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify. Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dir. of Patient Accounts Hospital 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Brandt McKean Margaret Walklett McKean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene L. McKean-daughter 1413 Cayton Rd. Florence. KY 41042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 10-30-2009 | Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Kaitlin 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, if com fictions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sm Omonth o disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 🗌 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy perform 1 □Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 1 ☐ Yes 🗖 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Fig. Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHGHI

State Registrar

Day, Year) CT 29 2009

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

32. Fegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Kensington

2. Date of Death

October 26, 2009 Year

4c. County of Death

Portugal

Race - American Indian, Black, White, etc.

Silver Spring, Maryland

Approximate Interval Between Onset and Death

more than 3 yrs

Specify: White

Montgomery

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 11, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F Months Days Hours 578-80-4575 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Hygiene.
other than "natural", or items 23a or 2007.
rent, the Medical Exeminant hyperproperty. Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3229 University Blvd., West 20895 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 25 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □ No Completed by 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Gregorio Martins Maria do Carmo ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mario F. Martinho/Son 302 Plainview Avenue, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) October 29 Gate of Heaven Cemetery 5 Other (Specify) 2009 21. Signature of Funeral Service Licens 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) P.O. 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Atherosclerotic Cardiovascular Disease 24a. Was an Division of Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year)

Registrar's Signature

1. Decedent's Name (First, Middle, Last)

Joaquim Martinho

4a. Facility Name (If not institution, give street and number)

3229 University Blvd., West

Physician

/Medical

Examiner

23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2X No Other: 4 Nursing Home 52 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) October 27, 2009 7500 Greenway Center Drive, #430, Greenbelt, MD 20770

36135

3:11 a M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 XYes 2 □ No

Country) Fortugal

Registrar

within 24 hours after death To the Funeral Director: completely filled in by the

Medical

State

27. Manner of Death

1X Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Stephanie Trisoglio, MD

OCT 28 2009

5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

D37934

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36136 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ ^{Day} 2,2009 7:21 Рм Antionette Massie Sylvia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 12013 Hickory Drive Fort Washington 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours Director 225-42-1786 74 /10/1934 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Prince Georges MD Fort Washington 1 X Yes 2 □ No 10f. Zip Code 20744 10e. Street and Number 10g. Citizen of What Country? 12013 Hickory Drive Funeral USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: "natural", **Black** Completed 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) EEOC Accountant be filed \ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eldridge Cooke Viola Giddens permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Kingsway Road Fort Washington MD 20744 Shelia Jackson/Daughter Baltimore, Date 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 009 10/222 Cheltenham MD 4 Dopation 5 Other (Specify) Cheltenham Vet. al Service Lig 21. Signutur 22. Name and Address of Facility 20019 Dunn&Sons 5635 Eads St. NE Washington DC 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line. nediate Cause (Final Physician. direase or condition sulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (dr as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No or Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnants 9 ☐ Unknown 1 Yes 2 L 9 Unknown be detached by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 After this certificate 2 🗌 No 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, 0009162

State Registrar OXON Hill

6194

4250

OXON H:11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. To

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 24a per phys. G897 11/16/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10-27-2009 **Physician** 10:45AM Dorothy Anne Mentzer /Medical lb. City, Town, or Location of Death Havre de Grace 4c. County of Death Harford 4a. Facility Name (If not institution, give street and number) Examiner 710 St. James Terrace 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Month Day,

9-29-1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Min. 215-24-7977 1 □ M 2 🛛 F 80 Hours Delaware Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 710 St. James Terrace 21078 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 页 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 No þ Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Family 18. Mother's Name (First, Middle, Maiden Surname) Ruth Timms 17. Father's Name (First, Middle, Last) Be James Francis Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
710 St. James Terrace, Havre de Grace, Maryland 21078 John Noble Mentzer (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Havre de Grace 11-01-2009 Maryland 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Angel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zerlman Functal Home, P.A. 21078 Signature of Funeral Service Licenses 123 S. Washington St. Havre de Grace, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTI disease or condition resulting in death) Immlb Due to (or as a consequence of): DVARIAN Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner EDCURPL FAILURE ESPOND TO TREAT Due to lo as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🛛 No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident N/A NA 1 ☐ Yes 2 🗆 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner requires that the death certificate be executed Box 68760, P.O. Records, Division of Vital To the Hospital or Attending Physician:

physician and s the burial-tran attending pl signed b page 2 should within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exx., in an unst by Indiffed at

Physician

/Medical

Baltimore, Maryland 21215-0036

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

30. Name and address of person who completed

cause of death (Item 23a) (Type, Print)

29c. License number

D0060532

29d. Date signed (Month, Day, Year) 10-29-09

21001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Charles Augustine Murphy Physician/ October 2009 3:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5503 Harford Street Churchton Anne Arundel 5. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 XM 2 ☐ F Funeral Days Hours 12/28/1939 Director Maryland 215-38-4242 69 Usual Residence of Decedent 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Churchton 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5503 Harford Street 20733 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1957-61 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **PEPCO** Mechanical Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Joseph Murphy Catherine Agnes Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol E. Murphy/Wife 5503 Harford Street, Churchton, Maryland 20733 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cromation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 10/22/2009 Edgewater, Maryland 21. Signature Funera 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician tas Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) signed by the a detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sig ; page 2 should b 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a. Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Watural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Descritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 within 24 hours To the Funeral I

only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vadim Gushchin, 227 St. Paul Place, 4th Floor, Baltimore, Maryland 21202

31. Date filed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:45 AM October NOVa K 2009 Donna /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ar Washington Baltimore clen Burnie Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 12/14/1946 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** Months Days Hours Min. Pennsylvania 1 □ M 2√□ F 165-40-0303 62 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, Ite Provided Examination to the traumatic event, Ite Provided Examination to other traumatic event, Ite Provided Examination to other traumatic event. 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8200 Kramer Court 21061 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. White Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Claims Adjustor Elementary/Secondary (0-12) College (1-4or 5+) Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Regis Holleran Louella Moss ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gail Martucci Daughter 2279 Dairy Farm Road Gambrills, MD 21054 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Atlantic Crematory 10/29/09 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility 851 Annapolis Road Jati Hardesty Funeral Home P.A. Gambrills,MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (ance disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform penormed? 1 ☐ Yes 2 **X** No certificate 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 phopatient 2 ER/Outpatient 3 DOA this (Certification: To After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, 28c. Injury at Work? 28d. Describe how injury occurred Year) 1 Natural 2 Accident 5 ☐ Pending investigation neral Director: A 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division of Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month,

Girvm

Balton

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beyone

00068976

09-08214 John O'Donnell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

John O Donnell		For State	tate of Maryland		icate of Death			. No. 21	<u>009 3614</u>						
Physician	n/ i	egistrar . Decedent's Name (First, Midd		-			2. Date of Death Month	Day Year	3. Time of Death 1607 hrs						
Medical Examin	-	John la. Facility Name (if not instituti	David		Donnell	own, or Location of	October 22	, 2009 4c. County of D							
		Memorial Hospital	on, give street and number	,	Cumb			Allegany							
Funeral Director		5. Social Security Number 235-35-7449	6. Sex 7. A	ge (In yrs. last 38	birthday) If Unde Months	r 1 Year If Under Days Hours	24Hrs. 8. Date of Birth Min. 10/21/		Birthplace (State or Foreign Country) Maryland						
ž.	-	Usual Residence of Decedent 10a. State 10b. County	,	10c. City. To	wn or Location				10d. Inside City Limits						
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farylan 28a-f sl	Director	10e. Street and Number			10f. Zip		10	g. Citizen of What	Country?						
h the N 3a or 5		16512 Honey		-		21555	i-2 / Specify Ves or No	USA	merican Indian, Black,						
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 ☐ I	Married 12. Was Deceder	3?	if Yes, specif	y Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	White, e							
ifter de	Y.	3 Widowed 4 D	ivorced If Yes, Give Year or Dates	f99 <u>3°</u>		X No specify:		Specify:	White						
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36 hin 72 e. than "	Completed by	Elementary/Secondary (0-12	College (1-4 o	5+)	Contra				mprovement						
215-00 e filed wir ial Hygien ced other nt, the M	Be Con	17. Father's Name (First, Middl John	e, Last) Joseph	O'Dor		Ver		ie	Cooke						
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	라	19a Informant's Name/Relation V. Marie O'Do			Rt 1 Box	254, Rid	nber or Rural Route Num geley, WV	26753							
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Balt permit. Departi Import injury	}	21. Signature of Funeral Service	dours		404 D	ecatur S	treet, Cumb	erland, l	MD 21502						
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Box 68760, e death certificate be executed the attending physician and red for use as the burial - transit	Medical	UNPENDED	AMENDED					23d. Date of d	elivery						
1876 Trificate ing phy as the l	M/us	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	LIVE BII II		2 Fetal death	3 Ectop	ic pregnancy	Month	Day Year						
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Fital sician: is certifirector	Be	25. Was case referred to med examiner?	7.1	atient 2 🗸 E	ER/Outpatient 3	DOA Other	Nursing Home 5	Residence 6	Other:						
of Vital Records, ing Physician: The law require Witer this certificate has been some latered director, page 2 should insertal director, page 2 should	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of (Month, Date)	injury sy,Year)	28b. Time of Injury	28c. Injury at Wo		how injury occurre	d						
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Division tal or Atteudi us after death.	Certification:	d	could not be etermined (Specify)	f Injury - At noi	me, farm, street, facto	ry, office building,	or Town,		of flatal floors (tempor) any						
Hospi 24 hou Funer rtely fil	Medical Ce	4 Homicide 29a. Certifier Check only one) 2 Medical E	g Physician: To the best of examiner: On the basis of	examination an	e, death occurred at the	ne time, date and p ny opinion, death o	place, and due to the cau	se(s) and manner and place, and du	as stated. ue to the cause(s)						
To the within To the comple	Med	29b. Signature and title of cer	and manner stat tifier	ea. /	2	9c. License numbe	er	29d. Date signed (Month, Day,Year)							
		aci	un.	124	·	O.C.M.E.		October 23	, 2009						
5 mel		30. Name and address of personal Zabiullah Ali, M.D.	son who completed cause Assistant Medical		23a) 111 Penn Stre	eet, Baltimore,	MD 21201								
Si Regis	tate trar	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ar) 32. Regi	strar's Signatur	re Carled										

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Reg. N2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2226 LEE OCTOBER 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** REGIONAL MEDICAL CENTER SALISBULY
If Under 1 Year | If Under 24 Hrs. PENINSULA WICOMICO Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1**⊠** M 2□ F Days Hours 52 MARYLAND 214-70-5416 Director JANUARY 05 1957 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Funeral Director GREENBACKVILLE ACCOMACK VIRGINIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Pages 1 and 2 should be filed within 72 hours after death with 23356 USA "natural", or items 23a 1486 ELLIS STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🗷 No If Yes. Give Specify. ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than, College (1-4or 5+) Health and Mental Hygiene. ENERGY ABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JEANETTE WILLIAM NORRIS IRENE ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any Injury or other trae 1486 ELLIS ST. GREENBACKUILLE, VIRGINIA 23356 PARKS MARY ANN 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 ■ Cremation 3 □ Removal from State OCT, 30 2009 OAK HALL, UA 4 ☐ Donation 5 ☐ Other (Specify) DOWNINGS COMETORY 22. Name and Address of Facility Fex & HOLSTON FUNERAL HEME 21. Signature of Funeral Service Licensee TOPE CHINCOTEREUE, VA. 5049 CHICKEN CITY ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINUTE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate I 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA 1 Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐No eral Director: A investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 Kcertifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) ETITI C 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** WILLIAM ALLEN PEARSON 12:40P M OCTOBER 2009 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 247 B SASSAFRASS ST. OUEEN ANNE'S MILLINGTON 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Days Hours 2/8/1954 Director 215-66-0566 55 Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show 1 XYes 2 ☐ No Director MD QUEEN ANNE'S MILLINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. 247 B SASSAFRASS ST. 21651 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 X Married 1 □ Yes **X**□ No If Yes, Give Year or Dates: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural", er than "natura , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 EQUIPMENT OPERATOR is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RICHARD PEARSON LOUISE SALLOWAY ပ permit. Pages 1 and 2 shoul Department of Health and Mi Important: If them 27 is mark any injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS K. PEARSON/WIFE 247 B SASSAFRASS ST. MILLINGTON, MD 21651 20a. Method of Disposition
1 Burlal 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE CEMETERY 10/23/09 SUDLERSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 21. Signatur of Funeral Service Licensee fron Fella 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opeet and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a I be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of ertifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Family Medicine Galena main st Chustertown M-32. Registar's Signature Year) State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #15 Per FH 10/28/09 CCHD DB Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2ª4 Month Year **Physician** Virginia Parbuoni 2009 OCTOBER 4:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PLATA CHARLES LA CINISTA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 18, 1916 Birthplace (State or Foreign Country)
 GA 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 M 2 GF 219-48-0717 Yrs 93 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the "hadical Examiner must be notified at Yes 2 □ No Director MD Charles La Plata 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 8 Walnut Hill Road 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 24 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White <u>≽</u> Specify 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other the any liqury or other traumatic event, the once. Nurse County Health Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Cotton Bivins Addie Belle Tyson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Parbuoni/Son P.O. Box 577, Port Tobacco, MD 20677 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Cemetery 10/28/2009 4 □ Donation 5 □ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee MO0945 22 AREHARI ECHOLS FUNERAL HOME, P.A. Eho Daw 211 St. Mary's Ave. La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Seprolegiel Coloulare disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any leading to initial addresses. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Full to for as a consumence offi sician and burial-tran Due to (or as a consequence of): انگرام Division of Vital Records, P.O. Box 68760, physician s the burial requires that the death certificate be Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 □Yes 2 ☑ No been signed by the should be detached 9 Hlnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy performed? Yes 2 2 No e Hospital or Attending Physician: The 24 hours after death.

P Funeral Director: After this certificate hietely filled in by the funeral director, page 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D56949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAMAKSHI BAIG MD 6620 CRAINHWY 6620 CRAINHWY#200 LAPLATTA MD 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2035 M RATHER 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Mandrin Hospice House Harwood 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day Jan 23 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Ye*ar)* 1929 1 □ M 2 Ø F Months Hours Maryland 217-26-2622 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 USA 570 Bellerive Rd. 21401 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐Yes 2 ☐ No Completed by If Yes, Give Year or Dates: Specify. Specify: Black 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other thar Custodian Medical Center 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Oueen Unobtainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau 12 Melrob Ct. Apt 101 Annapolis, Md. 21403 Cynthia Stewart (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10-23-09 Baltimore, Md. Winname Roverse of SeciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 **Physician** /Medical Examiner Physician/Medical Exam 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Medical Certification: To

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	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	respiratory arrest, Wata Hatu	Approximate Interval Between Onset and Death		
ICAI EVAIIIIICI	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last	b Due to (or as a consequence of): c Due to (or as a consequence of): d			
y Sicial Miles	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		pic pregnancy or (specify)		ate of delivery Jonth Day Year
picton by 1	Part II. Other significant conditions c	contributing to death but not resulting in the underlyi	ing cause given in Part I.	1 → Yes 2 □ No	attribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of
5				performed?	death? 1 □Yes 2 □No
	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 [26. Place of Death Other: 4 Nursing Hom	(Check only one) ne 5 ☐ Residence 6 ☐ Of	MANDAIN ther (Specify) HASAILE
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at 2 Work?	8d. Describe how injury occu	rred Ausc
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office 2	ber or Rural Route Number,	
5		nysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated.			
	29b. Signature and title of certifier	Henty un	29c. License number () 2/4/38	. 6 /	ed (Month, Day, Year) There is, 2009

Registrar DHMH 17 Rev 1/2001

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32 Registrar's Signature

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ANNAPOLS MDZIYLY

Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. LarENTAM

OCT 26 2009

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygier | | 9 Certificate of Death 2. Dete of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Lest) **Physician** 24 2009 **OCTOBER** 9:01 AM HOWARD ROLAND POWELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner OUEEN ANNE'S 610 ROBERTS STATION ROAD CHURCH HILL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1**X**M 2□ F Yrs. Director 214-46-2648 FEB. 2,1946 MARYLAND 63 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23e or 28a-f show traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No MD QUEEN ANNE'S CHURCH HILL Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 ROBERTS STATION ROAD 21623 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "netural", or ite 1 XI Yes 2 □ No If Yes, Give Year or Date **\$ 965-1971** 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Ď 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) TIDEWATER PUBLISHING 12 --0-BINDER FOREMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be t of Health and Mental PEARL WOOD JOHN WESLEY POWELL, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 602 ROBERTS STATION ROAD, CHURCH HILL, MD 21623 HEATHER GARNER/DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-29-2009 CHESTER CEMETERY CHESTERTOWN, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner the ettending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 23b, Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probabiy 4 Nunknown signed by 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1∟Yes 2MNo ILIYes ZLINo certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 5 Residence 6 □Other (Specify) nours efter death.

neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide edical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29h. Signature and title of certi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) or andre 120: SON 31. Date filed (Month, Dav. Year

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** \mathbf{P} M 9:17 GERALD WAYNE POTTS, JR. OCTOBER 24, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 342 BROOKE RUN LANE CENTREVILLE **QUEEN ANNE** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F AUG. 4,1965 OHIO Director 291-60-0218 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director r items 23a or 28a-f shiner is ust be notified 1X Yes 2 □ No CENTREVILLE **QUEEN ANNE** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21617 342 BROOKE RUN LANE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Xiyes 2 □ No If Yes, Give Year or Dates 1985—1990 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LAW ENFORCEMENT POLICE OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARLENE FAYE ENDICOTT GERALD W. POTTS, SR. ပ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 BROOKE RUN LANE, CENTREVILLE, MD 21617 KIMBERLY M. POTTS/ WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Pages 1
Department of H
Important: If ite
any injury or oti 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CALCUTTA UNITED PRES. 10-31-2009 CALCUTTA, OHIO CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

"In the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year P.O. □Yes 2□No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed use of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Prvor Clarence /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGA WMHS-MEMORIAL HOSP 9. Birthplace (Sta Country) Date of Birth (Month, Day, Yo Aug 25, . Age (In yrs. last birthday) (State or Foreign Social Security Number **Funeral** Min. 1 M 2 F Months 215-26-9825 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h. Count 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Cumberland Allegany 1 □ Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 220 Humbird Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by white 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Conductor Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Lester E. Pryor Virginia (Sirbaugh) Pryor ဥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Keith Pryor 409 Race Street Cumberland son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 11/7/2009 Cumberland MD 4 ☐ Donation _5 ☐ Other (Specify) 22. Name and Address of Facility al Home, PA 21. Signature of Funeral Service Licensee. 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Esquerniany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 X Inpatient Certification: To 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending To the nospersor within 24 hours after death.

To the Funeral Director: Aft Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ORIGINAL

31. Date filed (Month, Day,

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

State Registrar

36148 State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) M DOLK **Physician** Rilev Gary Michael /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Alleganu NMHS-Braddock Compus DO DO anc 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe **Funeral** Days 1 X M 2 □ F 214-42-0216 65 Director 01/25/1944 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 🔯 No Director LaVale MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 310 Sunset Drive 21502 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No 1961-If Yes, Give Year or Dates: 1967 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ∐Yes 2 🛣 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 Ith and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Railroad 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Riley Joseph John Yetieve Wilkinson traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traunonce. Sheila R. Riley / Wife 310 Sunset Drive, LaVale, Maryland 3altimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Cumberland Crematory 10/20/2009 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Service Licens 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SYSTONC Physician CONGESTIVE /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATH Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit or Attending Physiclan: The law requires that the death certificate be executed 4 LCO HOL Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, iis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 ⊠o Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 24 hours after death. Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number OCTOBER 20, 2009 900 Setow DRIVE ambercas.

State

W LLS

DHMH 17 Rev 1/2001

DR, William

32. Registrar's Signature

		•	For State Registrar	State	of Mar	•	partment of Fertificate of			ene . No 2009	36149
			Decedent's Name (First, Middle	e, Last)					2. Date of Death Month	Day Year	3. Time of Death
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1	/Medic Examin		4a. Facility Name (If not institution	n, give street and	number)		4b. City, Town, o	r Location of Deatl		4c. County of Deat	
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	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔯	_	(In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign untry)
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	and w	-	Usual Residence of Decedent 10a. State 10b. County			10c. City, Town or	Location				10d. Inside City Limits
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-	289	Director	10e. Street and Number				10f. Zip Code		100	. Citizen of What Co	untry?
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	deat deat	Funerai	11. Marital Status	12. Was [Decedent Ev	ver in U.S.	3. Was Decedent of H	dispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, White	
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a _Z	and N		19a. Informant's Name/Relations				ailing Address (Street				
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Baltimore,	iges 1 of of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal fo	rom State	cemetery,	sposition (Name of crematory or other pla			c. Location - City or	
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39	permit. Page Department i Important: if eny injury o		21. Signature of Funeral Service	Licensee	1						Home, P.A.
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			23a. Part1. Enter the disease, o shock, or heart failure. List	only one cause	nat caused ti on each line	ne death. Do not	I mode of dyl	ng, such as cardia	c or respiratory arres	il,	Approximate Interval Between Onset and Death
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Вох	ath cert attendin for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🗀 Li		Fetal death	3 Ectopic pregnand	ry .		23d. Date of de Month	Day Year
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ا يم	law requires that the de as been signed by the a 2 should be detached t	표	Part II. Other significant conditi	ons contributing	to death but	not resulting in th	ne underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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		0	25. Was case referred to medica	ıl-				26. Place of De	ath (Check only one	V	70.0
<u> </u>	ysici is cei direc	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	1 🔲 Inpatien	t 2 ER/Outpa	atient 3 DOA Ot	her: 4 Nursing I	Home 5 ☐ Resider	ice 6 Other (Spe	ocify)
0	Attending Physician: r death. sctor: After this certific. by the funeral director.		27. Manner of Death 1 Matural 5 ☐ Pendi	/	ate of Injury Month, Day	Year) 28b. Tim		iry at	28d. Describe how	v injury occurred	
Sio	Attending or death. ector: After by the funer	cati	Accident invest	igation not be				Yes 2 No			
		ertification:		nined 288. F	Place of Injur ouilding, etc.		, street, factory, office		City or Town,	eet and Number or R State)	ural Houle Number,
_	pltal	O	29a, Certifier 12 Certifyi	no Physician: T	o the hest of	t my knowledge o	leath occurred at the t	me date and plac	e and due to the ca	use(s) and manner a	s stated
	To the Mospital or within 24 hours afte To the Funerel Dis completely filled in	Medical		Examiner: On t		examination and/	or investigation, in my				
	within To the	Me	29b. Signature and title of certific	AT.			i	se number		d. Date signed (Mon	
	7			my for	21-		DO	033280		Etober	21,2009
,	`		30. Name and address of person	who completed	cause of de	ath (Item 23a) (Ty	/pe, Print)		3	7 1	21,2009 MO21553
	2 mel		Juni Gu	ptall	Deficiency	605 K	ent Hus	nue (umbe	chance,	111091209
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36150 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ rsologic 1:10 AM George Brenton RENNER III 2009 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days (Month Day, Year) ay 13, 1931 Hours 1 TX M 2 1 Maryland 78 May Director 213-24-8608 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 72 hours after death with the Maryland Director 1 🗌 Yes 2 🎦 No Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21740 9829 Garis Shop Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 1948-52 Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 X Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) sheet metal worker electrical of Health and Mental Hygi of Health and Mental Hygi If item 27 is marked other other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beulah Ann Hamby George Brenton Renner II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9835 Garis Shop Rd., Hagerstown, Maryland 21740 Wanda L. Kendle - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite 1 🔀 Burial 2 🗀 Cremation 3 🗀 Removal from State injury or Hagerstown, Maryland Cedar Lawn Mem. Park 11/2/09 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME any E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final cule √Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Oronari The law requires that the death certificate be executed and Due to (or as a consequence of attending physician for use as the buria Physician/Medical able Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
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State

Registrar

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park

SHED

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUR

32. R

ARID

OCT 30

31. Date filed (Month, Day, Year

			1 - For State Registrar	State of Marylar		artment of H tificate of			jiene 	9 36151
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Year	
S. Carlot	/Medic Examin		Nellie Irene Reid 4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, o	or Location of De	October	27, 2009 4c. County of De	6:20 P M
	LXuilli	Ü.	Julia Manor			Hagers			Washing	gton
	Funeral Director		217-30-0000	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H		3, 1918 Ma	irthplace (State or Foreign Country) ryland
	nyland how		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	8a-f e	Funeral Director	Maryland Washington	n Wi	lliamsp					1 ☐ Yes 2 🕱 No
	with ti	直	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What (Country?
	ns 23	era	17217 Sterling Road	. Was Decedent Ever in U	J.S. 13. V	21795 Was Decedent of R	Hispanic Origin?	(Specify Yes or No- lerto Rican, etc.)	USA 14. Race - An	nerican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3XXVidowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cub 1 ☐ Yes 2 /∏ tNo	an, Mexican, Pu Specify:	ierto Rican, etc.)	Black, Wh	
9	72 hou	ted	15. Decedent's Educa (Specify only highest grade)	ition	16a. Dece	dent's Usual Occup	pation	working	16b. Kind of Busines	s/Industry
21215-0036	within 7 ene. than *r	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+))	kind of work done DO NOT use retire usewife	d)	WORKING	Home	
	illed Hygid other		17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle,	Maiden Sumame)	
ylar	should be and Mental marked of umatic eve	To Be	Lewis Stanhope Shi	pley			1	Virgie Cl		
Maryland	od 2 sho lith and I 27 is ma trauma		19a. Informant's Name/Relationship (Type Martha Jane Reid -			ng Address <i>(Street</i> 7 Sterli 1			r, City or Town, State msport, MD	
	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. I		sition (Name of natory or other pla		The state of the s	20c. Location - City	
E	Pages nent of int: if it		MRBurial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	noval nom State		Mem. Pai		30-2009	Williamsp	ort,Maryland
Baltimore,	permit. Pages Department of H Important: If Ite any njury or of		21. Signature of Funeral System of Shaee	7					eral Home Williamsp	P.A. ort,MD 21795
* 1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the dea cause on each line. Due to or as a consecutive of the cause on each line.	th. Do not ent Quence of	er the mode of dyi	ng, such as card	diac or respiratory are MOMS Meef	egst, V	Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	Ical Examiner	fr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to as a consec	quence of):	file	on Us	ation Canco	4	Hears Days
687	ifficate g phys		d.	-6/66	1		onion	-		111
P.O. Box 6	Physician: The law requires that the death certificate be executed tribic certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	aldeath 3 ☐	Ectopic pregnance Other (specify)	у		23d. Date of o	Day Year
	quires that n signed b	þ	Part II. Other significant conditions control	ributing to death but not re-	sytting in the u	nderlying cause gr	ven in Part I.	23e. Did to		to the cause of death? Probably 4 Dunknown
Division of Vital Records,	The law requir ate has been si page 2 should I	Completed	Insulii	Dept.	gal	cesic l	Melli F	24a. Was a autop: perfor	sv / prior t	
/ita	Physician: The lithis certificate har all director, page	Be	25. Was case referred to medical examiner?					Death (Check only or	ne)	
on of	ding Physi J. After this c funeral dir	ion; To	27. Manner of Death A Natural 5 Pending	spital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju			ence 6 Other (S) ow injury occurred	pecify)
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str			28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Ceftifier 1 Certifying Physic (Check offly one) 2 Medical Examine	cian: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the ti vestigation, in my	me, date and pla opinion, death o	ace, and due to the occurred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	~			se number	21.	29d. Date signed (Mo	nth, Day, Year)
			No	(MM)		200	450	21	04 20	200 7.
31	4-5		30. Name and accress of person who cut	pleted cause of death (Ite	m 23a) (Type,	Print)	antie	Jan St	HAG 1	3 200 8. UD21740
SV-V	Sta Registr		31. Date filed (Month, Day, Year) 0 C.T 29 200	32. Registrar's Sign	ature	ale	-			-

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For	Pleas	e Type or Prin State of Ma		d / Depa	artment of H	Health and I		_	
		1 - State Registrar				Cei	rtificate of	Death		Reg. No.	
Physicia		1. Decedent's Nam	ne (First, Middle, RO(2. Date of Dea	Day Year	
/Medic		4a. Facility Name ('If not institution,	give street and number)			4b. City, Town, o	or Location of Death	1	4c. County of Dea	ath
Funeral Director		3940 Bex 5. Social Security N 577-22-8	Number 6	4 PM 4 A PRINCE	ne (In yrs. la	a <i>st birthday)</i> Yrs.	Suitla If Under 1 Year Months Days		8. Date of Biri (Month, Da Aug. 3	Prince (h, Year) 9. Bi 7, 1922	Georges rthplace (State or Foreign country) DC
p >		Usual Residence o	f Decedent 10b. County		100 City	Town or Lo	cation				10d. Inside City Limits
e Maryla a-f shov lifted at	Director	MD		Georges	,	tland	Cattori				1 □Yes 2 🖾 No
or 28	Oire	10e. Street and Nu					10f. Zip Code			10g. Citizen of What C	ountry?
ath wi	ral	3940 Bex	ley PL.	819			20746			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In Medical Eventine that the molified anone.	by Funeral	11. Marital Status 1 Never Marr 3 Widowed	ried 2 Marrie	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 □Yes 2⊠ No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		
"natura	Completed I		15. Decedent's			16a. Dece	dent's Usual Occup kind of work done	pation during most of world)	king	16b. Kind of Busines	
withlir lene. than	dmc	Elementary/Second	ondary (0-12)	College (1-4or 5	5+)		enger & C	_		Dept of	Interior
filed Hygi other ent, I	Be C	17. Father's Name	(First, Middle, L.	ast)				T-	ne (First, Middle,	Maiden Surname)	
fenta fenta ked ilc ev	To B	Thomas	Roots					Eunice	Marie J	ames	
shou and N s mai		19a. Informant's N	lame/Relationshi	p (Type. Print)	-	19b. Mailir	ng Address (Street	t and Number or Ru	ıral Route Numb	er, City or Town, State,	Zip Code)
and 2 salth in 27 l		Eunice B	utler-Da	aughter		9701	Hale Dr.	Clinton	n, Md. 2	0735	
Pages 1: nent of He nt: If iten				B ☐ Removal from State			sition (Name of matory or other pla tion Cem		Date 30-2009	20c. Location - City of Clinton,	
permit. Departm Importa any Inju		21. Signature of Fu	· · · · · · · · · · · · · · · · · · ·		ord	1 1 N	Name and Adde		l Home o	f Maryland	
Physician		23a. Part 1. Enter to shock, or hea Immediate Cause disease or condition	art failure. List o (Final	omplications that caused nly one cause on each li	ne			-		rrest, Feart D.	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	- 1	Due to (or as	a consequ	ence of):					
cuted of the state	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	S	Due to (or as	a consequ	ence of):					
ate be executed hysician and he burial-transit		resulting in death)	Last	Due to (or as	a consequ	ence of):		<u>-</u>			
Attending Physiclan: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	lelivery Day Year
uires that the de	þ	Part II. Other signi	ificant condition	s contributing to death b	out not resul	Iting in the u	nderlying cause gi	ven in Part I.		obacco use contribute	to the cause of death? Probably 4 Onknown
The law requirecate has been spage 2 should	Completed								24a. Was auto perfo 1 🗆 Yes		
iclan: The	Be	25. Was case reference examiner?	rred to medical	Hamital			100	26. Place of Dea	ath (Check only o	one)	
Phys this	P.	27. Manner of Dear		Hospital: 1 Inpati		ER/Outpatier 28b. Time o	IL 3 LI DOA			dence 6 Other (Sp.	pecify)
ending sath. or: After the funer	cation	1 ☑ Natural 2 ☑ Acci d ent	5 ☐ Pending investiga	(Month, Da	ly, Year)	Injury	Wo	rk?]Yes 2 □ No	Zou. Describe		
tal or Att rs after d al Direct ed in by	Certification:	3 ☐ Suicide 4 ☐ Homicide	determin	28e. Place of in	ury - At hor c. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To	Street and Number or a wn, State)	Rural Route Number,
To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)		Physician: To the best xaminer: On the basis of and manner st	of examinat						
With Som	Σ	29b. Signature and	title of certifier	n 1923	to	90	29c. Licen		.7	29d. Date signed (Mo.	
A.		30. Name and add	ress of person w	ho completed cause of a	death (Item	23a) (Type,	Print)	rive c	Lever	October 3	zland
Sta Registr		31. Date filed (Mor		32. Registr	rar's Signat	barkse	1			>/	
		901	A A FAAA	La Marine	10.	A 60 cd ida.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36153 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 Cecelia M. Roedig 3:25P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shangri-La Ellicott City Howard If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 □ M 2 F Days Months Hours Min 107471919 201-09-5876 Director 90 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 341 Greenlow Rd 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify. 27 is marked other than "natural", traumatic event, the Medical Exa Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Receptionist Orphanage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ဂ္ Joseph M. Roedig Theresa Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therese V. Webbert - sister 341 Greenlow Rd. Catonsville, MD 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tu 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Holy Sepulchre Cem 10-29-2009 Cheltenham, PA 22. Name and Address of FacilitHarry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Japens M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): The law requires that the death certificate be executed nding physician and use as the burial-transi Exal that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year g Unknown signed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Completed 1 Yes 2 No 3 Probably 4 Onknown certificate has be irector, page 2 sl

.Physician/

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

24b. Were autopsy findings available prior to completion of cause of death? autopsy

1 🗌 Yes

25. Was case referred to medical examiner? 1 Tes 2 L No 27. Manner of Death

26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at

4 Nursing Home 5 Residence 6 Other Specify 28d. Describe how injury occurred

performed?

1 Natural 5 Pending ☐ Accident Investigation 6 Could not be 4 Homicide determined

work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 LATON AVENUE, BALTIMONE, MANY LAND RICHARDSON MO.

State Registrar 32. Registrar's Signature

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, i

Be

Certificate:

Medical

State of Maryland / Department of Health and Mental Hygienes o

			for State Registrar	State of it	nai yiai i	Cei	rtificate of	Death	iu ivie		g. No.	09	36	154
	Dhysisi		1. Decedent's Name (First, Midd	dle, Last)					2.	Date of Death Month	Day	Year	3. Time o	f Death
	Physicia /Medic		WILLIAM LEI	GHTER RAMSBU	RG II	I			0	ctober	-		2:00	PΜ
	Examin	er	4a. Facility Name (If not institution	-	er)		4b. City, Town, o	r Location of D	eath		4c. Count	y of Death		
			7807 Spout Spi				Freder		Llue I =			deric		
	Funeral Director		5. Social Security Number 216–48–6312	6. Sex 1. M 2 F	Age (In yrs. Id 65		If Under 1 Year Months Days		Min. J	Date of Birth (Month, Day, uly 31,	^{Year)} 1944	Cou	place (State ntry) yland	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	, Town or Lo	cation				-		0d. Inside C	ity Limits
	Mary f sh	to	Maryland Fred	ierick	Fre	ederic	k						1 ∐ Yes	2 No
	ith the Maryland or 28a-f show	irec	10e. Street and Number		1110	Jackson	10f. Zip Code			10	g. Citizen of	What Cou	ntry?	
	ath with 23a or ust be	al D	7807 Spout Spi	ing Road			21702	2			U.S	.A.		
	ter dea:	ıner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S	S. 13.	Was Decedent of H	lispanic Origin'	? (Specif	y Yes or No-		ace - Ameri ack, White,		
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Eversion of that by neutring a sone.	Completed by Funeral Director	12 Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 Yes 2	□No		1 □Yes 2 XNo			,,	Spec	fy:	ite	
5-0	72 hc	etec	15. Decede (Specify only high	nt's Education est grade completed)	- 3	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of	working	1	6b. Kind of I	Business/In	dustry	
2121	within ene.	dw	Elementary/Secondary (0-12)		r 5+)			d)			D . 1.			
2	iled v Hygie ther i	ပ္ပိ	17. Father's Name (First, Middle	l (ast)		1	Welder	18 Mother's	Name (F	First, Middle, M			ervice	!
an	Mental arked or atic eve	To Be	William L. Ran						•	ebecca.		•		
ar y	shoul nd M marl	ř	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailir	ng Address (Street	L					Code)	
Ž	nd 2 alth a 27 is		M. June Ruffne	er / Sister		1	3 Old Ann				-			93
J.e.	ges 1 and of He If item		20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name of natory or other place	ce)	Date	2	0c. Location	- City or To	wn, State	
<u><u>Ë</u></u>	Page nent ant: II ury o		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 ∐ Removal from Stat Specify)			et Cemete		/26/0	09 Fr	ederi	ck, M	ary1an	d
Baltimore, Maryland	permit, Page Department Important; II any Injury or once,		21. Signature of Europeal Service	Licensee	1805	X RO	Name and Addre OBERT E. 201 NORTH	SS of Facility DAILEY	& S(ON FUNE	RAL HO	OMES,	P.A.	61
			23a. Part 1. Enter the disease, of shock, or heart fail ha.	or complications that caus	ed the th							LOK,	Approximation Interval Be	
	Physician	1	Immediate Cause (Final disease or condition	and the cause of second	10 80	estit	ic Vase	uler	die	ease	-	4	Onset and	Death
	/Medical		resulting in death)		is a consequ		•						***	
	Examiner	_	Sequentially list conditions.	b										
	ed sit	ine	if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequ	ence of):								
	and and II-tran	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	is a consequ	ence of):								
68760,	tificate be executed g physician and as the burial-transit	<u>a</u>												
687	ificate g phy as the	edic		d										
O. Box	attendir for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnanl 9 ☐ Unknowr	2 ☐ Fetal at time of de	death 3	Ectopic pregnand Other (specify)	ey .				ate of deliv Ionth	-	Year
Д,	ding Physician: The law requires that the de. h. After this certificate has been signed by the funeral director, page 2 should be detached	y Ph	Part II. Other significant condit	ions contributing to death	but not resu	Iting in the ur	nderlying cause giv	en in Part I.		23e. Did tob	acco use coi	ntribute to t	he cause of	death?
Records,	quires nn sign ald be	d by	-						_	1 Yes	s 2 □ No	3□ Pro	oably 4□	Unknown
ပ္သ	s bee	Completed								24a. Was an		. Were auto	psy findings	available
æ	The Is	ome		-					_	autopsy perform 1 □ Yes 2	ed?	prior to co death? 1 ☐ Yes	mpletion of o	cause of
ita	lan:	BeC	25. Was case referred to medica	al				26. Place of	Death (C	Theck only one		1 1 162	2 🗀 🗤 0	
<u></u>	hysic his ce I direc		examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 🗆 E	ER/Outpatien	nt 3 DOA Oth	er: 4 🗆 Nursir	ng Home	5 Resider	nce 6 🗆 O	ther (Speci	fy)	
ū	ing Pi	ou:	27. Manner of Death 1 ☑ Natural 5 ☑ Pendi	28a. Date of Ir (Month, L	njury Da <i>y, Y</i> ea <i>r)</i>	28b. Time of Injury	Wor		280	l. Describe how	v injury occu	rred		
sio	tendileath.	cati		igation				Yes 2 □ No						
Division of Vital	I or Attend after death. Director: / d in by the fi	Certification: To		minod 28e. Place of I	njury - At hor etc. <i>(Specify</i>	me, farm, stre	eet, factory, office		281.	Location (Str. City or Town,	eet and Nun State)	ber or Run	al Route Nun	nber,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the best I Examiner: On the basis and manner	of examinat	wledge, death ion and/or in	n occurred at the ti vestigation, in my o	me, date and popinion, death o	olace, and	d due to the ca at the time, da	use(s) and r te and place	nanner as , and due t	stated. o the cause(s)
	To the within To the complete	₩	29b. Signature and title of certific			D	29c. Licens	se number		29	d. Date sign	ed (Month,	Day, Year)	
				AN	m		Da	D546	36	,	10-2	6-6)9	
P	5+1	ŀ	30. Name and address of person	n who completed cause of	death (Item	23a) (Type,	Print)	- ;						
Ó	J 1 1		Syed Haque		onto	lair	e Ave	trede	ric	K ma	21	701		
	Stat Registra		31. Date filed (Month, Day, Year	26 2009 >	stran's Signat	ure A.	parke	č				-		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4c. County of Death Allegany 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Campus Ser (and If Under 24 Hrs. 8. staddock 5. Social Security Number If Under 1 Year 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 215-26-7593 1 □ M 2 🗷 F Months Days Hours Director -20-Usual Residence of Decedent purmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a fine for could be could 10c. City, Town or Location 10a. State 10b. County ELLERSLIE ALLEGANY **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number MASON DIXON 10302 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify Specify: Whit

36155

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Physician /Medical

3 ☐ Widowed 4 ☐ Divorced

this certificate within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

P.O. Box 68760,

Division of Vital Records,

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital within 24 hours a To the Funeral C

Completed by 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home ome mai Ker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leydic mary m_{UL} မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1030Z MASON DIXON VIEW ELLERSLIE MA 21529 Robert L. SEE Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Buffalo Mills 10/26/04 Madley 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harvey H. Zeizler Funeral Home Inc 169 Clarence ST HYNDMAN PA 15545 23a. Part | Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Stolo 1 Dopatient 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fegistrar's Signature State Registrar

Please Type or Print in Black Indelible in k2 Fn swe All Copies Are Legible.

Amend Item 24a per phys. State of Maryland / Department of Health and Mental Hygiene 36156 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1.0 . Medical Ahaa Suh 2009 8:00 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5500 Lexington Rd. Apt. Baltimore 302 Woodl<u>awn</u> 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. (Month, Day, Year) 8/14/1928 Director 217-94-0633 Korea Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10d. Inside City Limits MD Baltimore Woodlawn 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5500 Lexington Rd. Apt. 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Midowed 4 □ Divorced Specify: Asian marked other than "natur matic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ t. Page 1 and 2 should be functed the should be functed the state of Health and Menta tant If item 27 is marked jury or other traumatic evil Nanpuk Lee Maejoo Ko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elise Ma - daughter 4588 Kingscup Ct. Ellicott City, MD 21042 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Marriottsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. andre amato 4112 Old Columbia Pike Ellicott City, MD 21043 M00845 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner grun Sequentially list conditions, Examine if any leading to introduct cause. Enter Underlying Cause or linjury Hospital or Attending Physician: The law requires that the death certificate be executed mas 5 MA sate has been signed by the attending physician and page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant Unknown 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 025654 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mn van Registrar's Signatur State 2009

DHMH 17 Rev 7/2009

Registrar

park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SARAH TURPIN SENECAL OCTOBER 24ay 2009 11:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 190 EMORY FARM LANE QUEENSTOWN OUEEN ANNE'S 5. Social Security Number **Funeral** . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours 95 OCT 8 Year 1914 Director 577-64-7900 ALABAMA Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 275 marked of other than "natural", or items 23a or 28a-f sho mary injury or other traumatic event, the Medical Examiner must be notified at 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MARYLAND QUEEN ANNE'S QUEENSTOWN 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 190 EMORY FARM LANE 21658 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: WHITE 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ WILLIAM POTTER TURPIN MAY BIBB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE HABBERTON/DAUGHTER 190 EMORY FARM LANE, QUEENSTOWN, MD 21658 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State LOCUST HILL FARM 4 Donation 5 Other (Specify) CENTREVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS Add HELFENBEIN & NEWNAM FUNERAL HOME, P.A 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Genera PREMIT Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or inijury that initiated events AVE Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ne ~1 N attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital မ 1 🗌 Yes 2 40 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injurv 5 Pending 1 Yes Accident
Suicide 2 No Investigation Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of ce

Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

VILLAS

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22 OCTOBER 2009 12:30A M MARK ALLEN SMITH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 18609 WASCHE ROAD DICKERSON MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAR 17 9. Birthplace (State or Foreign 6. Sex ^{Year)} 1979 1 ☑ M 2 ☐ F Months Days Hours Min. 217-92-4665 30 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MONTGOMERY POOLESVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17654 KOHLHOSS ROAD 20837 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWARD DAVID BENNETT TERRY LYNNE SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY BENNETT / MOTHER 17654 KOHLHOSS RD., POOLESVILLE, MD 20837 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service License MONOCACY CEMETERY 10/24/09 BEALLSVILLE, MD 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTRO INTESTINAL HEMORRHAGE Due to (or as a consequence of): STRESS ULCER PROBABLE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If Item 27 Is marked other that any Injury or other traumatic event, Inc. and Once.

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

10a, State

MD

Examine

signed by the attending physician and I be detached for use as the burial-transit icate has been si , page 2 should b

P.O. Box 68760

of Vital Records,

Division

filled in by the funeral

death certificate be executed The law requires that After this certificate To the Hospital or Attending Physician: death. within 24 hours after deatl To the Funeral Director: completely

Medical

23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician/Medical δ Completed Be ၉ Certification:

State Registrar

25. Was case referred to medical examiner? 1∐Yes 2☑No 27. Manner of Death 1 ☑ Natural

CEREBRAL PALSY

☐Yes 2☐No 9 Unknown

2 Accident 3 ☐ Suicide

29a. Certifier

(Check only one)

5 Pending investigation 6 ☐ Could not be determined 4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4 Pregnant at time of death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

MD 0000995

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) OCTOBER 26, 2009

23d. Date of delivery

Day

3 Probably 4 Unknown

HOUSE

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

2 1 No

1 ☐ Yes

2 No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specific ANDMOTHERS

Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

1 ☐ Yes

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASUNCION, HECTOR C. 18730 GERMANTOWN RD., GERMANTOWN, MD 20874 MD

CHRONIC MUSCULAR SKELETAL PAIN

31. Date filed (Month, Day, Year) 32. Registra/s Signature 2009 26

3 Ectopic pregnancy

5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me, g3,98,12/04/09dhb Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year **BETTY** FLORENCE STITES October 12, 2009 11:35 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours Min. Year) 1 □ M 2 💢 F Yrs. Director 87 May 7, 1922 Australia 231**-**52**-**5494 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No Director Virginia Fairfax Chantilly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13708 Smallwood Court Funeral 20151 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ģ 1 ☐ Yes 2√∑ No Specify: Specify: White 3√√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Interior Decorator Home Design 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Robert Smith Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Stites / Son 13708 Smallwood Ct./ Chantilly, Virginia 20151 Robert 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) OCT.23,2009 | Arlington, Virginia Arlington National 21. Signature of Funeral Service Hoense 22. Name and Address of Facility

Stauffer Fun

1621 Opossumtown Pike/Freder

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, MD 21702 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Demention Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause followers or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗆 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 2**X** No 3 Probably 4 ☐ Unknown 1 ☐ Yes HUPERTENSION Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Cholesten 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 XYes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner The law requires that the death certificate be executed

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

item 27 is marked other than "natu other traumatic event, the Medical

burial-transi signed by the attending physician I be detached for use as the buria page 2 s certificate

P.O. Box 68760,

of Vital Records,

Division

ours after death.

neral Director: After this certificat
y filled in by the funeral director, p. Hospital or Attending To the Hospital within 24 hours a To the Funeral D

Certification:

Medical

29a. Certifier

(Check only one)

27. Manner of Leath **Vatural** Accident 3 Suicide 4 Homicide

5 Pending investigation 6 ☐ Could not be

28b. Time of Injury

28a. Date of Injury
Found 1, Day, Year)
07/24/2009 Unknown ^M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living Facility

28c. Injury at Work?

1 ☐ Yes 2 X No

28d. Describe how injury occurred Subject fell.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2100 Whittier Dr. Frederick, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signa d title of certifier 51643

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hirenkumar Shah 65-C. Thomas Johnson Dr./ Frederick, Maryland

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2009

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State of Maryland / Department of Health and Mental Hygiene 36160 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 3,2009 PAMELA ELIZABETH SELLMAN NOVEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Mar 18, Birthplace (State or Foreign Country)
 Towa 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 569-64-0119 65 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Woolfield at Maryland Director Frederick Frederick 1K Yes 2 □ No 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 207 Locust Street 21703 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 72 hours after 1 Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify Specify: Þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant NIH - Federal Governmet permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dade Sellman Hunton Priscilla Morrison ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Sellman Obler, Sister 4540 N Artesian, Chicago, Illinois 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Nov 4, 2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Signatur of Funeral Service Licensee M00706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstraction Sma 60W1 **Physician** /Medical Due to (or as a consequence of): Examiner vanah Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Due to (or as a consequence of): burial Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. signed by the a 9 I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed 24a. Was an cate has page 2 s certificate 1 □ Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2**™**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Larinova D65443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elena Iarikova, M.D., 400 West Seventh Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrario Signature State Registrar

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			for State Registrar		State	of Maryla			artment of F ctificate of		Mental H		200	Q	361	61
			Negistial Decedent's Name	(First, Middle, La	st)						2. Date of D	eath			3. Time of D	
	Physici /Medio		F	Richard E	Eugene	Smith					Month Novem	ber 3			4:10	P^{M}
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				ick Memor		_=	1-45-4	t1	If Under 1 Year	Frederic			Fred			
	Funeral Director		5. Social Security Nu 225-20-643		ex Mg M2□F	7. Age (In) 88		raay) rs.	Months Days	Hours Min.		yay, Year) 29. 1		Country	ce (State or V Vania	Foreign
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3	8a-f	Directo	Maryland		erick				Frederi	ck 		10 000			1 🔀 Yes 2	2 No
	3a or 2		10e. Street and Num 2502 Drif	twood Cour	t				10f. Zip Code	1702			zen of What nited S			
1	iems 2	Funeral	11. Marital Status		12. Was Dec		ı U.S.	13. V	L Was Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	Specify Yes or N to Rican, etc.)	0- 1	14. Race - A Black, W			
36	tal Hygiene. tal Hygiene. do other than "natural", or items 23a or 28a-f show event, tra ivedical Evariatari rust to notified a	by Fe	1 ☐ Never Marrie 3 ☒ Widowed		1 ∐Yes If Yes, G Year or D	ive			I∐Yes 2. XINo	Specify:				White		
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	hysician and burial-transit the prizal-transit	edical Examiner	23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death) Sequentially list continuous enter and light cause. Enter Under Cause (Disease or that initiated events resulting in death)	rt failure. List only Final 1 Inditions, mediate lying njury	a. Due to b. Lue to	(or a a cons	sequence o	of):	To (TO	4	c or respiratory	arrest,	pton	lr.	pproximate nterval Betwonset and De	een
J traff	atter for u	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	months?		birth 2□F nant at time	etal death] Ectopic pregnand] Other <i>(specify)</i> _	су		2	3d. Date of Month			əar
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_ 0	0 0 0	tion: T	27. Manner of Death 1 Matural		28a. Date (Mor		28b. Ti	<u> </u>	28c. Inju Wor		28d. Describe			эреспу)		
DIVISION	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	8 Could not be determined		e of Injury - A ing, etc. <i>(Sp</i>	t home, fari ec <i>ify)</i>	m, stre	eet, factory, office	1100 22110	28f. Location City or To	(Street and wn, State)	d Number o	r Rural F	Route Numb	er,
Hospitz	24 hours e Funera letely fille	edical C	29a. Certifier (Check only one)	Certifying Ph 2 Medical Exar	niner: On the I	e best of my basis of examiner stated.	knowledge, nination and	, death	n occurred at the ti vestigation, in my o	me, date and plac opinion, death occ	e, and due to th urred at the time	e cause(s) , date and	and manne place, and	er as sta due to th	ted. ne cause(s)	
To	withir To th comp	Me	29b. Signature and t	title of certifier		£			29c. Licens			29d. Date	e signed (M	onth, Da	ıy, Year)	
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			30. Name and addre	ess of person who						ick, Maryla	and 21701					
H	Sta Registr		31. Date filed (Monti	h, Day, Year) NOV		Registrar's 8	gnature	A	1. par							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTODE R 7:30AM **Physician** 2009 wana /Medical County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ree imber egany N a Date of Birth (Month, Day, Aug 7, 9. Birthplace (State or Foreign Country) Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Funera! Min 1 ☑ M 2 □ F Months Days Hours MD Yrs 215-34-4825 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 28a-f show Department of Health and Mental Hygiene. Interpretation of Health and Mental Hygiene. Interpretation of Health and Mental Hygiene. Interpretation of Health and Mental Hygiene. The mortant: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Modical Examiner must be redified at once. Cumberland 1 Yes 2 No MD Allegany **Funeral Director** 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21502 USA 11212 Creek Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ĎlYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: white þ 3 ☐ Widowed 4 ♣ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Body and Fender mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Willard Swanger Willa Ellen Mummert Swanger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11212 Creek Road Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Cumberland 11212 Creek Road ex wife Leona Swanger 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/4/2009 Restlawn Memorial Gardens MD LaVale 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or compliques shock, or hear failure. List only one adons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, reause on each line. Immediate Cause Final disease or condition resulting in deat 200 **Physician** /Medical Due to (or as a consequence of): Examiner mo) 14 Semo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐No cate has been signed by the spage 2 should be detached in 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No certificate 1 □Yes r this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) ည 28c. Injury at Work? Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie ical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

e Funeral C within 2.

State

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

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32. Registrar Signature NOV 0 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

2010941

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 36163 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 28, **Physician** 200[°]9° 2:25 Thompson Sarah Рм Jeanne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 4011 Mills Road Sharpsburg 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Days Hours Min. 48 March 14,1961 216-84-0509 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanding must be maiffind at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2 No Washington Director Maryland Sharpsburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4011 Mills Road Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Software Engineer Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Miles Dale Townsend ဥ Millie Mackubin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John K. Thompson / Husband 4011 Mills Road Sharpsburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2009 Frederick, Maryland 21. Signature of Funeral S rvice Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, 21713 Part 1 Enter the disease, or compications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NE 3 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15H-L 5 VX G de 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36164 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 0350A M October orraine laulor 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Center Kent hestertown MD21620 hester Kiver HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 220-26-8655 PA 78 Director 8/23/1931 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location traumatic event, the Wedical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **IISA** 21620 9190 NORTH BAYVIEW AVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married 1 ☐Yes 2 XNo Specify: If Yes, Give Year or Dates: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER CIVIL SERVICE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPHINE CHAMBERS FREDERICK WEHN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWRENCE C. TAYLOR/HUSBAND 9190 NORTH BAYVIEW DR., CHESTERTOWN, MD 21620 other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/20/2009 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final REFUNCTORY HYDOXCMIA + HYDOTCHSION **Physician** HOUR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 40415 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nding physician and Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEARCONATOD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy MABLECTUS certificate 2 No 1 ☐ Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) Turon MO PACS

Mr_s

3altimore, Maryland 21215-0036

Box 68760.

P.0.

of Vital Records.

Division

State Registrar

0

CHOSTOMOUN, MANYLAND 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4005 CNOSS

PAUL JOHNSON

Physician /Medical Examiner

Funeral Director

28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is not be very in the properties.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and Box 68760 To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physiciar P.0. Division of Vital Records,

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 26, 2009 5:00A M October Grace Delores Tomlinson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 10505 Cedarville Road, Lot 813 Brandywine If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 M 2 X 14, 1930 Maryland 579-38-2284 79 April Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Director MD Prince Georges Brandywine 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20613 USA 10505 Cedarville Road, Lot 813 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐Yes 2 X No 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No white Yes Give Specify þ Year or Dates: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Bartender Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Richards Edward J. Graney ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2804 Brewster Road, Waldorf, MD Debby Jones/Daughter 20601 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 10/27/09 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall,MD M00945 21. Signature of Funeral Service Licensee 22 AREHART-ECHOLS FUNERAL HOME, P.A. laur (1 211 St. Mary's Ave. La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Respiratory Failure Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence of: Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ∐Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month. Day, Year)

Registrar's Signature

09-08190 Michelle Ann Vaughn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

### Children ### Charles ###			F	- For State Registrar		ificate of	Death		Reg.	. No. 20	0.9	3616
Experience of the section of the sec			-	1. Decedent's Name (First, Middle,Last) Michele Alexa		n			2. Date of Death Month C October 21,	Day Year 2009	2223	hrs
2. Social Security Number 10 21 4 8 4 - 21 67 10 22 10 23 10 24 10 26 10 24 10 26 10				4a. Facility Name (if not institution, give			•	Location of Death		4c. County of De	eath	
214-84-2167 Mark State Coccurry Frostburg State Coccurry Frostburg State Coccurry State	_		4		7 Age (In yre Ia	et hirthday)		r If Under 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9.	Birthplace (S	tate or
The size of the control of the contr		_		214-84-2167	, ,					/1966 G	oreign Di Country) CC	strict
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Section Sect	he Marylan	or 28a-f sliffed at one	Directo		treet				10g			
22. Name and Address of Facility Durst Funeral Home. P. A Forst Ave., Frostburg, MD 21532 1532	eath with t	items 23a			Armed Forces?							n, Black,
22. Name and Address of Facility Durst Funeral Home. P. A Forst Ave., Frostburg, MD 21532 1532	ırs after d	tural", ot tminer m	2		If Yes, Give Yeer or Dates:				work done			
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22. Name and Address of Facility Durst Funeral Home. P. A Forst Ave., Frostburg, MD 21532 1532	MD 21.2 2 should b h and Men	27 is mar	ည									e)
Signature of Funeral Service Locases 22. Name and Address of Facility Durst Funeral Home P. A 57 Frost Ave., Frostburg, MD 21532 21532 238 Pgwf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near minimal part of the cause (Final disease) 238 Pgwf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near minimal part of the cause (Final disease) 238 Pgwf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near minimal part of the cause (Final disease) 238 Pgwf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near minimal part of the cause (Final disease) 238 Pgwf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near minimal part of the cause (Final disease) 238 Pgwf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near minimal part of the cause of death of the cause	more, Pages 1 and ent of Healt			1 Burial 2 X Cremation 3	¬¬ ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,	rematory or oth	er place)				-	
Manage Security	Baltie permit. I Departm	Importa injury o			* Devent	22. N	ame and Address 7 Frost	s of Facility Du Ave.,	rst Fun Frostbu	eral Ho rg, MD	me, P 21532	.A.
The state of the s	/Med	ical	18	failure. List only one cause on each	ch line.		ne mode of dying,	, such as cardiac	or respiratory arres	st, shock, or heart		kimate Interval en Onset and Death
Sequestially all commendate contributed by the contribution of the cause of the cau	xami	iner		or condition resulting in death)								
Second S			miner	if any, leading to immediate								
See Suppose the complete of the completed contribution of contributions of	ecuted	and - transit		events resulting in death) Last d.	· · · · · · · · · · · · · · · · · · ·	·):		_				
See Suppose the complete of the completed contribution of contributions of	. o,	ysician	edic							22d Date of de	livery	
29b. Signature and title of certifier O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	x 6876 h certificate	tending phy use as the	-	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fet		Ectopic pregn	ancy		•	Year
29b. Signature and title of certifier O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Bo ne deat	후장	hys			and the state of		aiven in Dert I	23a Did tot	pacco use contribu	te to the caus	e of death?
29b. Signature and title of certifier O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	P.O.	igned by	ð	Part II. Other significant conditions	contributing to death but not re	ssuling in the o	inderlying cause	given in Fait i.				
29b. Signature and title of certifier O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	cords, law requin	as been 2 should	npletec					_	autops perfori	y prio m <u>ed</u> ? dea	or to completion	n of cause of
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29b. Signature and title of certifier O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	/ital	uis cert directo	Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatient		Othor:		Residence 6	Other: Scene	
29b. Signature and title of certifier 29c. License number O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	on of \ nding Phy	After t funeral		27. Manner of Death	FOUND: Day, Year)	FOUND:						
29b. Signature and title of certifier O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Divisic tal or Atte	ral Directo lled in by t	ertifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, stree	et, factory, office	building, etc.	28f. Location (S or Town, St 66 West Main	treet and Number ate) Street, Frostburg	or Rural Route	e Number, City
29b. Signature and title of certifier 29c. License number O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	the Hospi thin 24 hou	the Funer mpletely fil		29a. Certifier 1 Certifying Physicia	an: To the best of my knowledge: On the basis of examination a	ge, death occur						s)
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To wit	T _O	Me	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed	(Month, Day,	Year)
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	4			Cardl He	Allan		O.C	.M.E.		October 22,	2009	
31 Date fled Whorly Bray Verrig and 32 Penistrar's Signature	se	٥					Street, Baltim	nore, MD 212	01			
State Registrar 31. Date filed (Month Par Year) 6 2009 32. Registrar's Signature for the signature f	P			31. Date filed (Month Par Year) 6 2	32. Registrar's Signatu	ire). Jaa	alle					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State C	of Maryland / Depa <i>Cer</i>	rtment of He rtificate of De		, ,	iene _{eg. No.} 200	9 36167
Physici /Medi		Decedent's Name (First, Middle, Last) Donald Vanaman				2. Date of Deat Month October	Day Ye	3. Time of Death
Examir		4a. Facility Name (If not institution, give street and not 1635 West Pulaski Highv 5. Social Security Number 6. Sex 1X M 2 F	Vay 7. Age (In yrs. last birthday)		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	4c. County of C	Death
Director		135–48–7906 Usual Residence of Decedent 10a. State 10b. County	54 Yrs.			May 16,	1955 N	ew Jersey 10d. Inside City Limits
r 28a-f sh	Director	Maryland Cecil 10e. Street and Number	E1kton	10f. Zip Code		1	0g. Citizen of Wha	1 □Yes 2 ሺ No
death with	Funeral D	1635 West Pulaski High		21921 Was Decedent of Hisp f Yes, specify Cuban,				American Indian,
13-0036 72 hours after death with the Maryland "natural", or items 23a or 28a-f show color! Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or I	2 No live 1 Dates:	l∐Yes 2 x No s	Specify:		Specify:	White, etc. White
5 2 E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College () (Give i (1-4or 5+)	dent's Usual Occupation kind of work done durit OO NOT use retired) mercial Sc	ing most of worki	ing	16b. Kind of Busin	
Maryland Z1Z1 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Mar	To Be C	17. Father's Name (First, Middle, Last) Robert Vanaman	T GOIN			·	Maiden Surname)	Life
0		19a. Informant's Name/Relationship (Type. Print) Danielle Vanaman / Daugh		g Address (Street and West Pulas				nte, Zip Code) y1and 21921
Daltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Mayerdale	sition (Name of natory or other place) Crematory	Octol	oer	20c. Location - City	
Dall permit. Departr Importa any inju		21. Signatu of Funeral Service Licensee	22	. Name and Address	of Facility Cro	ouch Fun	eral Hom	
beloou, itilicate be executed Examiner as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	each line.	er the mode of dying,				Approximate Interval Between Onset and Death
the death certificate the attending physiched for use as the	Physician/Medical	in the past 12 months?	gnant at time of death 5 □	Ectopic pregnancy Other (specify)			23d. Date o Month	
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Completed by Ph	Part II. Other significant conditions contributing to a	death but not resulting in the ur	4	in Part I.	23e. Did to 1 ☐ Yo 24a. Was a	es 2 No 3	probably 4 Unknown The autopsy findings available
VITAL ING ician: The la certificate has ector, page 2		25. Was case referred to medical		2	6. Place of Deat	autops perfors 1 □ Yes	prio med? dea 2 No 1 □	r to completion of cause of
r Attending Physici r Attending Physici ter death. rector: After this cer r by the funeral direct	ition: To Be	examiner? 1 Yes 2 No Hospital: 1 28a. Date	Inpatient 2 ER/Outpatien e of Injury nth, Day, Year) 28b. Time of Injury	other: 28c. Injury a Work?	4 Nursing Ho	me 5 Resid	ence 6 Other ('Specify)
LIVISI Ital or Atter Its after dea al Director led in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place build	e of Injury - At home, farm, stre ding, etc. <i>(Specify)</i>			City or Tow	n, State)	or Rural Route Number,
the Hosp thin 24 hou the Funer mpletely fil	Medical		te best of my knowledge, death basis of examination and/or inv nner stated.	vestigation, in my opin	nion, death occur	red at the time, o	date and place, and	due to the cause(s)
5 × 1		29b. Signature and title of certifier	AD	29c. License n	9324		29d. Date signed (A Octuber o	27,2009
Sta	te.	30. Name and address of person who completed cau Rener Perkus no 3 y 9 31. Date filed (Month, Day, Year) 32.	- n1.1 ;	twy &	Ikton,	MD &	11921	
Registi		OCT 2 8 2009 /2	A hall					

DHMH 17 Rev 1/2001

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Amend Pl line a & 25, per ME 8897 11/18/09 TT

State of Maryland / Department of Health and Mental Hygien 2009

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0752 M Ralph Denver Williams, Sr. 0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9 Birthplade (State or Foreign WMHS-Memorial Campus umberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 √ M 2 □ F 76 232-52-1920 Director 07/23/1933 West Virginia Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 28a-f show than "natural", or items 23a or 28a-f shov by Wedical Eventour , ust be notified at 1 ☐Yes 2√ No Director MD Allegany Rawlings 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22300 McMullen Highway 21557 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 NYes 2 No 1951-If Yes, Give Year or Dates: 1955 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 1955 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Denver Arthur Williams Eva ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health an Elizabeth A. Williams / Wife 22300 McMullen Highway, Rawlings, MD Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory: 10/14/2009 Cumberland, MD Big lature of Funeral/Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the buriaf-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) been signed by the s should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s performe (16) STRUC MUDI thouse 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1⊡**X**Yes 2⊡No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ mpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death.

Director: A id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Funeral (1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number October 13, 2009 LOGENT 5+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nRs Seton 04 Registrar's Sign State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinations to return at the notice.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Registr

	For State Registrar	State of Ma			cate of		nemai m	Reg. No.		20102
	1. Decedent's Name (First, Middle, Las	st)					2. Date of D	eath	Year	3. Time of Death
an al	Grace	Maxine	_1	Wels	1		10	24	2009	2336™
er	4a. Facility Name (If not institution, give	e street and number)		4b.	City Town, or	Location of Death		4c.	County of Death	
	WMHS-Memo	rial CAN	npus		Cum	ber/AX	10		HIRGO	exel
	5. Social Security Number 6. Security Number 1		(Ih yrs. last birth	Mo	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 02/17/	rth a <i>y, Year)</i>	₩oun	lace (State or Foreign
	215-20-0190	LIW ZX	80 Y	rs.			02/17/	1929	Pen	nsylvania
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	n			_	11	0d. Inside City Limits
ō	MD Alle	egany			erland					1 TYYes 2 □ No
rect	10e. Street and Number	garry			of. Zip Code			10a. Citi	izen of What Coun	trv?
al Di	514 Schlund Av	/enue				21502		Ü	USA	
ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was	Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N	0-	14. Race - Americ	
Be Completed by Funeral Director	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 🕅 N If Yes, Give Year or Dates:	lo		es 2∭No		7 110411, 010.7		Specify: White, 6	
eted	15. Decedent's Ed (Specify only highest grad	ucation			Usual Occup	ation during most of work	dina	16b. Ki	nd of Business/Inc	lustry
nple	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO N	OT use retired	duning most of work	arry	ľ		
Con	8			Hou	sekeep				Hospit	al
Be	17. Father's Name (First, Middle, Last)		lland at man	•		18. Mother's Nam		_		rout
٩	Arthur		hristman	1		Lelia		Вау	ااد	
	19a. Informant's Name/Relationship (7 Judy A. Isner / D		1		•	and Number or Ru More Pike				
	20a. Method of Disposition		20b. Place of I	Disposition	(Name of	ce)	Date	20c. Lo	ocation - City or To	wn, State
	1 ⚠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1			ark 10/28	3/2009	Cun	mberland,	, MD
	21. Signature of Funeral Servicer licen	(ee)		22. Na	me and Addre	ss of Facility Ada	ams Fam	ily E	Funeral H	Home, P.A.
	House	Clabox	K	401	Decat	ur Street	c, Cumb	erlar	nd, MD 2	21502
	23a. Part 1. Ent the disease, or compositions shock, or heart failure. List only of	olications that aused	the death. Do no	ot enter th	e mode of dyir	ng, such as cardiac	or respiratory	arrest,	1	Approximate Interval Between
	Immediate Cause (Final		ichia	Azu	G Nax	nond.	1 1.1	1-		Onset and Death
	disease or condition resulting in death)	a	a consequence of):	. 0	10	Try.	~~~		50 Mil
		. Cr	voranz	on	tens	1/1 Scare				6 month 1
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseque of):	\mathcal{O}					
E.	Cause (Disease or injury that initiated events	C.								
Ä	resulting in death) Last	Due to (or as a	a consequence of):						
ical	L	d								
Med	IE EEMALE:									
an/l	ZSD. Was decedent pregnant	23c. If yes, outcome		3 ☐ Ect	opic pregnanc	v		1	23d. Date of delive	-
sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at 9 ☐ Unknown	time of death		er (specify)	*			Month	Day Year
Phy	9 Unknown						00 5::	4-1		
Be Completed by Physician/Medical Examiner	Part II. Other significant conditions or	ontributing to death bu	it not resulting in	ne underl	yıng cause giv	en in Part I.				ne cause of death?
ted							1	Yes 2[⊔ No 3∐ Prob	Dably 4 Unknown
ble							24a. Wa	s an opsy		psy findings available mpletion of cause of
М							per	formed?	death?	· _
3e (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)		
10	1 Yes 2 No	Hospital: 1 ☐ Inpatie			DOA Oth	er: 4 ☐ Nursing H	ome 5 Re	sidence	6 ☐ Other (Specif	y)
ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. Ti <i>(, Year)</i> Inj	me of ury	28c. Injur Wor	ryat k?	28d. Describe	how injur	y occurred	
cati	2 ☐ Accident investigation				/ 1 -	Yes 2□No				
ij	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	ry - At home, farr :. <i>(Specify)</i>	n, street, t	actory, office		28f. Location City or To	(Street an own, State	nd Number or Rum e)	I Route Number,
S	-	1								
Medical Certification: To	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and	death oco /or investi	curred at the ti gation, in my o	me, date and place ppinion, death occu	, and due to th rred at the time	e cause(s e, date and) and manner as s d place, and due to	stated. o the cause(s)
Me	29b. Signature and title of certifie				29c. Licens	e number		29d. Da	te signed (Month,	Day, Year)
		In lamer			De	03328	6	Oc	+ 26,2	700
	30. Name and address of person who	dmpleted cause of de	eath (Item 23a) (1	vpe. Print	•	,,-1				
Ш	Sunil K. Gu	v				Cumberlan	nd, MD	2150	02	
	31. Date filed (Month, Day, Year)		r's Signature	11	2,		, 			
te	31. Date filed (World, Day, Tear)									

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 36170 For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2009 October 24, 4:20 **Physician** Wrigley Warren /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) May 16, 1 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Oklahoma Hours Months Days **Funeral** 1944 1 → M 2 □ F 65 223-64-2435 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 1 □Yes 2X No d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Silver Spring Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 20902 901 Arcola Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyyes 2 □ No If Yes, Give Vietnam Black, White, etc. 11. Marital Status 1 TayYes 2 ☐ If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married White 1 □Yes 2 No Specify Specify: altimore, Maryland 21215-0036 Š 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) Education Teacher 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hant; If Item 27 is marked oth lury or other traumatic eventions Be Alice Louise Scott John Henry Wrigley 19a. Informant's Name/Relationship (Type. Print) -Conservator 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DC 20036 1001 Connecticut Avenue, NW, Suite 1137, Washington Karen J. Miller, Esquire 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Oct. 27, Alexandria, VA Department of Important; If It any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 27 Name and Address of Collins Funeral Home Inc 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only I ne cause on each line Immediate Cause (Final Respiratory Failure **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No 9 Unknown the detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe page 2 s 1 ∐Yes 2 😾 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🖾 No P this 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of After thi funeral 28a. Date of Injury 27. Manner of Death Certification: al or Attending F (Month, Day, Year) injury *Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier October 25, 2009 D56691 uno 6+1 of person who completed cause of death (Item 23a) (Type, Print) 30 Name and ad res 1500 Forest Glen Road, Silver Spring, MD 20910 Ghousia Sultana, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 28 2009 Registrar

			For State	State of Ma	ryland / Dep	artment of H rtificate of L		, 0				
_			Registrar 1. Decedent's Name (First, Middle, Las)	*)		Tillicate of L	Jealii	2. Date of Death	3. No. 2	009	3.3m6f	171
ы	Physicia	an			r Whita			Month October	Day	Year	9:05	P ^M
	/Medic		Vermelle Corlo: 4a. Facility Name (If not institution, give		I WIIILA	4b. City, Town, or	Location of Doct			ty of Death	9:03	P
	Examin	er	Laurel Regional	·		Laur				ince G	enraet	c
	Funeral		5. Social Security Number 6. Se	-	(In yrs. last birthday,	If Under 1 Year		8. Date of Birth (Month, Day,			lace (State of	
	Director			□M 2.2 X F	84 Yrs.	Months Days	Hours Min.	May 10,	1925	Wash	try) ington	DC.
			Usual Residence of Decedent					,		1		,
	irylan show	_	10a. State 10b. County		10c. City, Town or Le					10	0d. Inside Cit	
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	or 2		10e. Street and Number			10f. Zip Code		10		f What Count	-	
	ath v	ral	9550 Canterbury			207				ed Sta		
	item:	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ace - America ack, White, e		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:	'	1 □Yes 2X No	Specify:		Spec	ify: Am	erican	
Ş ,	tura		15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation	10	6b. Kind of	Business/Ind		
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21.	d with	Completed	12 years	College (1-40f 5+		rical Work	ker		Gov	vernme:	nt	
Maryland 21215-0036	al Hy lothe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, Ma	aiden Surna	ime)		
<u>a</u>	uld b Ment Ment arked	20	Thomas Leroy But	ler, Sr.			Eva Ja	ckson				
<u>a</u>	2 sho and sumi	i v	19a. Informant's Name/Relationship (T	/pe. Print)		ng Address (Street &					Code)	
≥ ·	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examines must be notified at once.		Maureen Chamberla	iin - Daug		Canterbu						
9	ges 1 t of H if ite or otl		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ I	Removal from State		osition (Name of matory or other place				n - City or Tov		
֓֞֝֟֝֟֝ <u>֚</u>	t. Part tmen tant: jury		Donation 5 ☐ Other (Specify))	rt .	ek Cemeter	• 1	- 1		ington	•	
Baltimore,	Depar mpor iny In		21. Signature of Funeral Service Licens	How k	11	2. Name and Addres				_		
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			23a. Pa 1.1. Enter the disence, or comp shock or heart failure. List only o	ne cause on each line).				SI,		Approximate Interval Betwonset and D	veen
	hysician		Immediate Cause (Final disease or condition resulting in death)	a	oscleroti	Cardiova	ascular l	Disease				
	/Medical Examiner		Toolising in docum,		consequence of): es Mellit	15						
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X P	m cer rendir	N/N	230. Was decedent pregnant	23c. If yes, outcome of		☐ Ectopic pregnancy	,			ate of delive	-	
n ;	he att	sicia	in the past 12 months? 1 □Yes 2 ☆No	4 Pregnant at t		Other (specify)			N	/onth	Day Y	'ear
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<u>က်</u> ဦ	es m signed	þ	Part II. Other significant conditions co Hypertension	ntributing to death but	not resulting in the ι	nderlying cause give	en in Part I.	23e. Did toba				
Hecords,	een s	Completed					****	1 ∐ Yes	2 □ No	3 ☐ Proba	ably 4 KJ U	Inknown
ည္	nas b	adr.	Renal Failure					24a. Was an autopsy		. Were autop prior to con	osy findings a	ivailable ause of
	cate	S						performe 1 □ Yes 2	ed? ☑No	death? 1 □ Yes	2 □No	
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10	this aldir	은	I les SKIMO	1 ∐ Inpatien	t 2 XER/Outpatie	nt 3 DOA	4 Nursing H	ome 5 Residen			<u>)</u>	
ב ב	After After funer	<u>o</u>	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) Zeb. Time C	Work	rat ? /es 2 □ No	28d. Describe how	injury occi	irrea		
VISION OT	or attending rrystotan: after death. Director: After this certific in by the funeral director, I	ical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Injur	y - At home, farm, st		res Z 🗆 No	28f. Location (Stre	et and Nun	nher or Rumi	l Boute Num	her
$\frac{2}{5}$	after Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	oot, lactory, office		City or Town,	State)	iber of flurar	House Hum	761,
, de	uithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Phy	sician: To the best of	my knowledge, dea	h occurred at the tin	ne, date and place	e, and due to the car	use(s) and	manner as st	tated.	
3	e Fu	Medical	(Check only 2 ☐ Medical Exam one)	iner: On the basis of e and manner state	examination and/or in	vestigation, in my op	pinion, death occu	rred at the time, dat	e and place	and due to	the cause(s)	I .
Ę	Veithii Comp	Me	29b. Signature and title of certifier	$\overline{}$	-	29c, License			d. Date sign	ned (Month, E	Jay, Year)	
			1/am W.	1 Sunda) ms	DZ	296	6 1	0/2	1/21	009	
`	4	Ì	30. Name and address of person who co		ath (Item 23a) (Type,	Print)			-1-	-1		
_	1		Thomas H. Burgu			an Dusen F	Road Laur	rel, MD 20	0707			
	Stat Registra		31. Date filed (Month Day Year) CT 2 8 2009	32. Registrer	's Signature							

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) walcuft Month udrag 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Pikesville Arden Courts If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 15, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🔀 F 291-22-0030 1923 Kentucky 86 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☑ No Baltimore Pikesville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21208 USA 8909 Reisterstown Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Conn Griffith Gusie Halterman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8216 Tally Ho Rd. Timonium, MD 21093 Charles C. Walcutt, Jr. 20c. Location - City or Town. State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 10/26/2009 Cheltenham, MD 22. Name and Address of Facility Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ardio Vancular Disease Immediate Cause (Final There disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery ant 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗆 No 1 □Yes 2 medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

ns 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Event in traumantone.

altimore, Maryland 21215-0036

Funeral Director

Completed by

Be

MD

Maryland

the

/Medical

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buntal-transit Be Completed by Certification: To

Division of Vital Records, P.O. Box 68760.

resulting in death) Last
IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 □Yes 2 ☑No 9 □ Unknown
Part II. Other significant
25. Was case referred to

and manner stated.

1∐Yes 2☐No 27. Manner of Death

5 ☐ Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at Work?

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

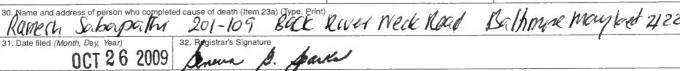
29c. License number 0 30 64 1

29d. Date signed (Month, Day, Year) October 21 2009

State Registrar

Medical

31. Date filed (Month, Day, Year) 26



			For State Registrar		State of M		nd / Depa	artme	nt of H		Mental Hy	/giene Reg. No	^ອ ວກກ _ູ			
	Physici /Medio		1. Decedent's Nam		.ast) ll Winpigle	er					2. Date of Domestin		2 2 0 0 °	3. Time of Death 8:00 P M		
- N.	Examin			_	rial Hospit			4b. Cit		r Location of Dea lerick	th	40	County of De			
*	Funeral Director		5. Social Security 1	Number 6.			last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hrs Hours Min		rth lay, Year,	939 9. E	Birthplace (State or Foreign Country) Maryland		
	aryland show dat	<u>-</u>	Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	ocation	-					10d. Inside City Limits 1 □Yes 2 ☒No		
	h the Ma r 28a-f r notifie	Director	Maryland 10e. Street and Nu	Freder	ick]	Freder		ip Code			10g. C	itizen of What			
	23a c		8329 Wa	ılter Mar	tz Road				2170				United	States		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Midral Eximiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2⊠ Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 □Yes 2 X If Yes, Give Year or Dates:	•	-	Was Dec If Yes, sp 1 □Yes		Hispanic Origin? (an, Mexican, Puel Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Al Black, WI Specify: W			
Maryland 21215-0036	hin 72 ho e. an "natur Motical	Completed	(Spe	15. Decedent's cify only highest g	Education grade completed)	5+)	16a. Dece (Give life.	dent's Us kind of w DO NOT	ual Occup rork done use retire	pation during most of wo d)	orking	16b. F	Kind of Busines	ss/Industry		
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and	be fill ntal H ed oth	Be	17. Father's Name		,						me (First, Middle		_			
IZ I	should nd Me mark matic	은	19a. Informant's N	W. Winp			19h Maili	na Addre	ss (Street		V. Robe		City or Town, State, Zip Code)			
Ma	nd 2 salth all			en Winpi	,	e								land 21702		
Baltimore,	Pages 1 a nent of He nt: If item ry or othe				Removal from State		Place of Disponentery, crea	osition (N matory of	ame of other plac	oe) Oc	_{Date} tober	20c. L	ocation - City	or Town, State Maryland		
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	cate be executed physician and the burial-transit	dical Examiner	Sequentially list or if any, leading to in cause. Enter Undo Cause (Disease or that initiated event resulting in death)	S	cDue to (or as	·										
P.O. Box 6	Physician: The law requires that the death certificate the this certificate the search signed by the attending physical director, page 2 should be detached for use as the base.	Physician/Medic	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknowr	2 months? □No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	aldeath 3	⊒ Ectopic ⊒ Other (pregnanc specify)	ey			23d. Date of Month	delivery Day Year		
rds, F	uires that n signed b Id be deta	by	Part II. Other signi	ificant conditions	contributing to death t	out not res	ulting in the u	nderlying	cause giv	en in Part I.		tobacco Yes 2		e to the cause of death? Probably 4 Unknown		
I Records,	: The law require cate has been si, page 2 should b	Completed									24a. Wa: auto peri 1 □Yes		prior	e autopsy findings available to completion of cause of 1? Yes 2 \(\subseteq \) No		
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se Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	06171
State of Maryland / Department of Health and Mental Hygiene UUS	36114
Certificate of Death Reg. No.	

Physician	
/Medical	
Examiner	

Funeral Director

r than "natural", or items 23a or 28a-f show the Predice! Examiner must be netflied at Pages 1 and 2 should be finent of Health and Mental of Health and Ments
If Item 27 is marked
or other traumatic even

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

permit, Pages Department of Important: If It any injury or o

and burial-trar attending physician for use as the buria signed by the detach has 24 hours after deatle Funeral Director:

Completed

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31. Date filed (Month, Day, Year)

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2009

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 4, 2009 Cecilia Wampole 7:25A.M Mary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Nursing and Rehab Walkersville Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New Hampshire 5. Social Security Number 1 □ M 2 X F Months Days 002-16-1608 85 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Walkersville 1 □ Yes 2 □ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 56 W. Frederick Street 21793 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: white δ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary B. Hunkins Louis Α. Lee ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Moxley / daughter P.O. Box 268, Newville, PA 17241 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cem. 11/9/2009Frederick, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford FH w MO1222 106 E. Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final STROKE 2 week disease or condition resulting in death) Due to (or as a consequence of): preumonitis 2 week Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 11-4-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tou House Ave Frederick MD 21701

Registrar DHMH 17 Rev 1/2001

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within 2 To the

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32. Registra Signature

State of Maryland / Department of Health and Mental Hygiene 36175 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 4, 2009 6:56 a ^M Stephanie Rae Weaver /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb 26, 19 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🕅 F 219-68-9720 1958 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exercises. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Frederick Maryland Frederick 1 Mayes 2 □No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 387 Pearl Street 21701 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Narried 1 ☐Yes 2X No Specify. Specify: White 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager-Administration Bowling Alley 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin Edgar White Sr Marie Virginia Perkins ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 387 Pearl Street, Frederick, Maryland 21701 Carol Robin White, Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory Nov 5, 2009 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M00706 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Uterine Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to initioulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Ye ar ō in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Type II Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Physician: The this certificate 1 □Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier completely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) Nov 4, 2009 29c. License number 29b. Signature and title of certifie D47101 am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wing Tam, M.D., 195 Thomas Johnson Drive, Frederick, Maryland 21702 32. Registra Signature 31. Date filed (Month, Day, Year) State NOV Registrar

			_ State	State of Mar	yland / I	Departme <i>Certific</i> a				000	0 06176
	61	,	Registrar 1. Decedent's Name (First, Middle, Last)		57	Certifical	.0 01 2	caur	2. Date of Dea		3. Time of Death
	Physicia Medic	al	James R 4a. Facility Name (if not institution, give str		Young	4b City	Town or	Location of Dea		er ^D 3 ^y , 2009 ^r	1830 м
	Examin	er	Kline Hospice Hou				Mt. A	iry		Frederi	.ck
	Funeral Director		100 24 0034 1	M 2 □ F 7. Age (1	n yrs. last birt 8	hday) If Under Months	Days	If Under 24 Hr Hours Mir		^{9. Bi} 23, 1931 Pe	rthplace (State or Foreign Duntry) ennsylvania
	ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick		Oc. City, Town				_		10d. Inside City Limits 1 Yes 2 □ No
	rith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 7 Wyn Court				p Code 217	 01		10g. Citizen of What C	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 X Yes 2 No If Yes, Give 19 Year or Dates.)	If Yes, spe	cify Cubar	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
Baltimore, Maryland 21215-0036	ithin 72 hour lene. r than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)			Decedent's Usi (Give kind of we life. DO NOT us Finance	ork done di e retired)	uring most of w	orking	16b. Kind of Business	overnment
land 2	2 should be filed within 72 th and Mental Hygiene. 77 is marked other than " traumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last) Ralph F. You						ame (First, Middle, I erine Rod		
, Mary	d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type Mrs. Rochelle T. Y	. ,					ok, MD 21	City or Town, State, Z.	ip Code)
more,	Page 1 an nent of He ant: If iten any or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemete	f Disposition (Na ry, crematory or Sburg Ci	other place		Date v. 5, 200	20c. Location - City of Smithsb	
Balti	permit. Departr Importa any inju	2 2 3	21. Signature of Funeral Service Lidensee	ed Mo	00255	Keene 106 E	yd Addred ast C	Basfor hurch S	d PA Fune	eral Home erick, MD 2	21701
4	Physician/ Medical	8 7	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)		sive	not enter the mo	de of dying	, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Ons t and Death
E	Examiner	iner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a c	rced	Panci	reat	s'a c	ance (3 months
0	cate be executed physician and the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a c	onsequence	of):					
. Box 68760	requires that the death certificate been signed by the attending phy should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live Birth 2 4 Pregnant at til 9 Unknown	Fetal deat	h 3 🗌 Ectopio 5 🗍 Other (s		y		23d. Date of de Month	Blivery Day Year
ls, P.O.	uires that th n signed by lid be detac	by	Part II. Other significant conditions conti							bacco use contribute to	o the cause of death? Probably 4 Unknown
Record	The law requate has been bage 2 shou	Completed							24a. Was a autop: perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a ver det. In the the transfer of the the transfer the certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completed filled by the funeral director, page 2 should be detached for use as the burial-transic	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Ho 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	spital: 1	28b.	utpatient 3 🗆 [Fime of njury M	Othe 28c. Injury work	4 ☐ Nursing at	eck only one) Home 5 Resid	ence 6 🖫 Other (Specow injury occurred	Fline
Division	ial or Attendi sa er decth. al Director: A ed i by the fu	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (rm, street, facto	ry, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours a er decth. To the Funeral Director: After thi completed filled by the funeral	Medical	only one) 3 Certifying Nurse I	r: On the basis of exar	mination and/o	or investigation, in ledge, death occ	my opinio urred at the	n, death occurre time, date and p	d at the time, date ar place, and due to the	nd place, and due to the cause(s) and manner as	cause(s) and manner stated. s stated.
	Voiti Co		29b. Signature and title of certifier	/	me) _	c. License	186	56	November 4	
			30. Name and address of person who con 468 The may Tol	ipleted cause of deat	th (Item 23a) (Type, Print) K	FI	an frederic	t mo	21702	
ï	Star Registra		31. Date filed (Month, Day, Year)	9 2009 strar's		A. A.	park.	1			

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State of Maryland / Department of Health and Mental Hygien 2009 36177 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ocT 26, **Physician** 2009 11:08 pM Lillian Zingg Kravis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death #905 Examiner Montgomery 3310 North Leisure World Boulevard Silver Spring 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Yrs. 4, 98 NOV 1910 Pennsylvania Director 159-07-1231 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "neturel", or iteme 23a or 28e-f ehow treumatic event, it a Modical Examination man be notified at 1 ☐ Yes 2√2 No Directo Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 3310 North Leisure World Blvd., #905 20906 death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No UN— 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: Caucasian Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: KNOWN <u>ک</u> 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 Is marked other then "no United States Elementary/Secondary (0-12) College (1-4or 5+) Department of State Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (UNAVAILABLE) Kravis Ethel Nathan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar fitem 27 lt or other tr 400 Greenbrier Dr., Silver Spring, MD 20910 Ellen K. Hamburger / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 iment of 1 itent: If it 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. `4 □Donation 5 □Other (Specify) Atlantic Crematory 10/28/2009 Glen Burnie, MD 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. 21. Signature of Fundal Service Licens Muc M00956 933 Gist Avenue, LL, Silver Spring, MD 20910 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FAILURE TO THRIVE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): ng physician a as the burial Box 68760 pe t Physician/Medical d. attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į, in the past 12 months? 1 ☐ Yes 2 XNo Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 🌠 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe rmed? 2 **X**No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 0 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospitel or Attending P 124 hours after death. e Funerel Director: After t Certification: 5 Pending investigation 1 XNatural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 To the I within 2 29d, Date signed (Month, Day, Year) 29b. Signature and tyle of certifier 29c. License number D 38457 October 27, 2009 no completed cause of death (Item 23a) (Type, Print) Nakul Goyal, M.D., 3801 International Drive, #211, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signatur State 28 2009 OCT Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For State Registrar			, and the second		tificate of	Health and Death		Reg. No. 🤈 🐧	00 30	170
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Examin	er	9511 Dee:		give street and numb	er)		4b. City, Town,	or Location of Death bia	1	4c. County	_	
Funeral		5. Social Security N	umber 6	6. Sex 7	. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs.			9. Birthplace (State Country)	or Foreign
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and show	or	10a. State	10b. County	-	10c. City	, Town or Loc	ation			-	10d. Inside	City Limits
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ath wi	Funeral	9511 Dee:	rioot w	12. Was Deced	ent Ever in U.S	. 13. W	as Decedent of	Hispanic Origin? (Sp	pecify Yes or No-		- American Indian,	
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of He		20a. Method of Disp		B ☐ Removal from S		ace of Dispos emetery, crem	sition (Name of atory or other pl	ace)	Date	20c. Location -	City or Town, State	
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Depar Impo any ir		21. Signature of Fu	ineral Service Lic	censee M	1044						Family F	
		23a. Part 1. Enter t	the disease, or o	omplications that cally one cause on each	used the death						Approxin Interval B	n <i>a</i> te
hysician/		Immediate Cause (disease or condition	(Final	Co	gesti	ue h	earl f	en luve			Onset an	
Medical Examiner		resulting in death)	-	42	as a consequ		. 1	1,				
	Jer	Sequentially list co if any, leading to in	onditions, nmediate	D. —	as a consequ	ence of):	cony a	i seale		-		
and -transit	xaminer	cause. Enter Under Cause (Disease or that initiated events	erlying linjury	C. —	,		Į.					
g 25 G	ш .	resulting in death)	Last	Due to (or	r as a consequ	ence of):						
illicate be exe ng physician a as the burial-	Physician/Medical			d								
attending pl		IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outco			F-1-1		e of delivery	of delivery		
ueann ne atte ed for	sicia	in the past 12 t	XNo		inth 2 □ Feta ant at time of d wn		Other (specify)	ncy		Mor	nth Day	Year
requires that the been signed by the should be detached	Phy	9 Unknown Part II. Other signif		s contributing to dea		ulting in the un	nderlying cause	given in Part I.	23e. Did to	obacco use contri	ibute to the cause o	f death?
signe d be c	Completed by	atrial fibrillation anemia, Hypercluster 1 - Yes 2 - No 3 - Pro								3 Probably 4	Unknown	
s been	olete				,		. /1		24a. Was		Vere autopsy finding prior to completion o	js available
ate ha	Com								auto perfo 1 Yes	ormed?	leath? Yes 2 No	r cause or
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ospital of Attending Property of the property	Certificate:	1 X Natural 2 Accident	5 Pending Investiga		flonth, Day, Year) injury			28c. Injury at work? M 1 Yes 2 No		ascribe now injury occurred		
ter dez irector	ertif	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	28e. Place o	f Injury - At ho	me, farm, stre	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)				mber,	
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2. ⊼ 3 ≡	Medical		ı ∟4¥Gertifvina l	Physician: To the bea								
n 24 hou n 24 hou ne Funei sleted fil	Jed		☑ Medical Ex	aminer: On the basis Nurse Practioner: To								manner state
to the nospital or Attending Priysician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Med		Medical Ex				eath occurred at 29c. Licer			e cause(s) and ma 29d. Date signed		manner state

State Registrar

30. Name and address of person.

ALB CHERIAN 101
31. Date filed (Mon OCT 28 2009

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MGB CHERIAN 10910 Little Patux ent Plany #105k, Columbia Md 21044

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 23, 2009 11:30 Grace Martha Zappala /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/11/1944 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛣 F 212-52-5714 Pennsÿlvania Director 64 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ir than "natural", or Items 23a or 28a-f show Silver Spring 1 X Yes 2 No MD Montgomery Director 10f. Zip Code 20906 10g. Citizen of What Country? 10e. Street and Number United States 2905 Beaverwood Lane death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 📉 No <u>Ş</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. Government 12 Janitor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orazio George Zappala Angela Bocalo of Health and Menta item 27 Is marked r other traumatic e 19a. Informant's Name/Relationship (Type. Print) Sister-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Zappala/ in-law 1901 Sunrise Drive POtomac, MD 20854 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemet. 10/27/2009 Silver Spring, MD 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Tung Cancer 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval Between Opset and Death MONTHS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran-Due to (or as a consequence of): HPPALA, CAACE 16/23/19 2320 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or A. Within 24 hours after death.

To the Funeral Director: After this certificate the Armeletely filled in by the funeral director, pag performed' 1 ☐ Yes 2 TxNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Marient 2 ☐ ER/Outpatient 3 ☐ DOA 2E No 1 ☐ Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/24/2009 D37891 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arajvanshi MD 121 Congressional Lane Rockville, MD 20852 31. Date filed (Month, Day, Year) State 28 2009 OCT Registrar

			1- For Amend Item 195 tate of Maryland / Department of Registrar	artment of Health and M rtificate of Death	lental Hygie	2009	36180		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) FLORENCE A DAMS		2. Date of Death	2009	3. Time of Death		
ned.	Examir	er	4a. Facility Name (If not institution, give street and number) COURTLAND GARDENS	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE			
	Funeral Director		5. Social Security Number 220-22-1694 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) 11-25-19	/ear) 9. Birth Coul	place (State or Foreign htry) MD		
	the Maryland 28a-f show	tor	10a. State			1	0d. Inside City Limits 1 □ Yes 2 X No		
	with the 3a or 28a	Funeral Director	10e. Street and Number 7920 SCOTTS LEVEL ROAD	10f. Zip Code 21208	10g	g. Citizen of What Cour	ntry?		
036	urs after death al", or items 2 xantiner man	Ş	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married	Nas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I □ Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,			
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Madical Experience reast be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workii DO NOT use retired) 1AKER	ng	bb. Kind of Business/In			
Maryland	be d c	To Be C	17. Father's Name (First, Middle, Last) ABRAHAM BRILL	18. Mother's Name		iden Surname)	FISHER		
, Mar)	d 2 s th ar 7 is trau			g Address (Street and Number or Rura LEYMAR ROAD, GLEN	,	,	/		
Baltimore,	. Pages 1 and tment of Heali tant; If item 2 jury or other		20a. Method of Disposition 1 1 2	sition (Name of natory or other place) DESH BETH ISRAEL 1	ate 20 1 – 11 – 2009	C. Location - City or To	Wn, State		
Ball	permit. Pag Department Important; any Injury o		seed on with	Name and Address of Facility SOL REISTERSTOWN	ROAD, PIK	KESVILLE, N	RS, INC. 1D 21208		
	Physician /Medical Examiner	or.	Due to (or as a consequence of): Sequentially list conditions b.	er the mode of dying, such as cardiac co		1	Approximate Interval Between Onset and Death		
28760,	cate be physicia the bur	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). C						
.O. BOX	or the rospital or Attending Prysician: The law requires that the death certification to the robust after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		Ectopic pregnancy Other (specify)		, 23d. Date of delive Month	ery Day Year		
ras, r	quires that an signed t uld be dete	è	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to the			
i necor	: The law re cate has bee	Completed		24a. Was an autopsy performe	ppsy prior to completion of cause of death?				
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	or Attending iter death. irector: Afte n by the fune	Certification:	Denoting investigation Suicide Gould not be determined Could not be building, etc. (Specify) Could not possible of the specific process. Could not be building, etc. (Specify) Could not possible of the specific process. Could not be building, etc. (Specify) Could not possible of the specific process. Could not be building, etc. (Specify) Could not possible of the specific process. Could not possible of the spe	Work? M 1 □Yes 2 □ No		et and Number or Rura	l Route Number,		
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	vithin To the comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,			
7			30. Name and address of person who completed cause of death (Item 23a) (Type, F	-D15872	1 21	209	1000		
	Stat Registra		31. Date filed (Month, Day Year) 2009 22. Registrar's Signature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 November 5:35 P Josephine 8, Victoria Arbutus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Timonium Stella Maris Hospice Ctr. 9. Birthplace (State or Foreign Country) Michigan If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 X F Hours Yrs 17,1925 Director 84 377**-**20-9254 April Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It o Madical Examinar must be recitled at 1 ☐ Yes 2 ☐ No Director Nottingham Maryland Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number 21236 United States 9411 Gunview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2√√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify: þ Specify ¥Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Mushlock Gregory F. Romanik 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21236 (Daughter) 9411 Gunview Road Nottingham, Maryland Denise Craft 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Sacred Ht. of Jesus Cem. 11/12/2009 Dundalk, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 21222 7922 Wise Ave. Dart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARBUTUS ital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 ☐ Yes 2,**Z**No 1 □Yes of Vital in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) IOSEPHINE IVISION OF VI Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a ca 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only nd manner stated To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, TIMONIUM, MD 21093 M.D.2300 DULANEY VALLEY ROAD Registrar's Signature State Registrar

2009

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NOVEMBER

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2009 November Esther Helen Antlitz 9:15am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster 8. Date of Birth (Month, Day, May 14, Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. **Funeral** Months Days Hours 1 □ M **2**√□ F 88 Yrs 213-12-6088 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Mcdical Examiner must be notified at MD Carrol1 Eldersburg 1 □Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1030 Stone Brook Road Unit A 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes Y ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: g Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetic. Elementary/Secondary (0-12) College (1-4or 5+) Administrator Shelter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Francis Kelly Rose E. Aro 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John T. Antlitz, III (Son) 15028 Kenwood Ct., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 11/12/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee TGHT Box Address of Facility FUNERAL HOME & CHAP 195 Sykesville, MD M00764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician WHOWA WK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ slocke 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sl autopsy performed 2 ₽No 1 ☐ Yes 2 -NO 1 □ Yes r this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1/5 SPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation in 24 hours after the Funeral Director: After the Funeral Director of the funeral pitch filled in by the funeral funer 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ull Au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, NOV 12 32. Registrar's Synature State Registra

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 10, 2009 5:30 Joseph Frank Anselmo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Collingswood Nursing and Rehabilitation Center 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 11€ M 2 □ F 577-42-1392 77 May 4, 1932 Washington, D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1x Yes 2 No r 28a-f sh notified Director Maryland | Frederick Frederick filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 21701 2678 Brook Valley Road United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1∑Yes 2□No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced ss 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Draftsman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be.
Department of Health and Mental I.
Important: if fem 27 is martiany or other? Be ٩ John Anselmo Margaret Cosimano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley J. Anselmo/Wife 2678 Brook Valley Road, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 13. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gate of Heaven Cemetery 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. gutte Ken M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 , or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner DIVIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (br as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | signed by the a Id be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? inderlying cause given in Part I. Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 🕱 No page perform 0 2 No Division or Vital Physician: 25. Was case referred to medical funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Marsing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 9 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Cular Br. 0110 TAID

DHMH 17 Rev 1/2001

State Registrar egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month enner NOV. 5 2009 1950 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL 310 HIGHLAND DR. GLEN BURNIE If Under 1 Year | If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 XX Months Days Hours Min. 69 220.36.3359 OCT.12, 1940 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 □Yes XX No ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 310 HIGHLAND DR. 21061 UŞA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes ≥ ZXXo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2XXMarried 1 □ Yes 2 📈 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL A. ECKER HELEN DORSEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 508 1/2 S. FRANKLIN ST., HANOVER, PA SON 17331 MICHAEL McROBIE 20b. Rlace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XXCremation 3 Removal from State 4 □ Donation 5 ☐ Other (Speci IEW CREMATORY INC. NOV. 09, 2009 BALTIMORE, MD 22. Name and Address of Facility FINK FUNERAL HOME, P.A. MC1148 426 CRAIN HUY.S., CLEN BURNIE, MD 21061 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Qnset and Death shock, or heart fall Immediate Cause (Final disease or condition resulting in death) Due to (or as a con Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be 2 MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item Mones.

Examine

physician and the burial-transi Physician/Medical attending for use as s been signed by the should be detached þ Completed certificate has birector, page 2 s funeral director Medical Certification: To Be After this Within 24 hours after death.

To the Funeral Director: Af

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnative birth 2 Fets 4 Pregnant at time of 9 Unknown	I death 3 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 ☐ Yes 2 ☐₩6	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆	DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	ry occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
	ysician: To the best of my kno iner: On the basis of examina and manner stated.				s) and manner as stated. d place, and due to the cause(s)

29d. Date signed (Month, Pay, Year)

State Registrar

29b. Signature and Atle of certifie



death (Item 23a) (Type,

				State of Maryland Department of Health and No. 12.09 dnb. 1.1/12/09 dnb. Certificate of Death	Mental Hygie Reg.	ne 2009	36185
		Physici	an	1. Decedent's Name (First, Middle, Last)	A April 1	Day Year	3. Time of Death
4	- de maria	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
	- Andrews		п	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		N	place (State or Foreign
	H	Funeral Director	١.	3. Social security Number 6. Sex 7. Age (iii yrs. last birthday) Wonths Days Hours Min.	8. Date of Birth (Month, Day, Ye		intry Caroling
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		r 28a-f show	ctor	MD NA Baltimore	<u>,</u>		1 Nes 2 No
		with th	I Dire	10e. Street and Number 10f. Zip Code 2 (2) 29	10g.	Citizen of What Cou	intry?
		r death	nnera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
3	980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Modical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo If Yes, Give 1 ☐ Yes 2 ☐ Mo Specify: Year or Dates:		Specify: B	lack
50m	21215-0036	"natur	leted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work ##e. DO NOT use retired)		b. Kind of Business/Ir	ndustry
32	212	d withir giene. er than	omo	Elementary/Secondary (0-12) College (1-4or 5+) SeamStress	F	FF U	nitorn
	and	t be file intal Hy ed othe	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name 19. Mother	e (First, Middle, Mai	den Surname)	
7	Maryland	should and Men s marke	2	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru	ral Route Number, Ci	ity or Town, State, Z	ip Code)
£	e, M	1 and 2 Health a sm 27 is ther tra		Koy Brown, Jr - Son 1270 Wood-bowner 20a. Method of Disposition 20b. Place of Disposition (Name of	Date 200	L Location - City or T	MD 21239
ROSA	altimore,	Pages nent of int: If its iry or o		1 Burial 2 Scremation 3 Removal from State 4 Donation 5 Other (Specify)	709 7	3altimon	Le MD
W.	Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Evanthar must be, once.		21. Sunature Emeral Service Licens 22. Name and Address of lacility 4.	well I	-unera	e Home
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,	LTT TYTOLE,	Approximate Interval Between
4	-	Physician	i P	Immediate Cause (Final disease or condition resulting in death)		1	Onset and Death
	7	/Medical Examiner		Due to (or as a consequence of):			
		ted isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
Q	oʻ	ficate be executed physician and s the burial-transit	Examiner	that initiated events c. Due to (or as a consequence of):			
3		icate be physici the bu	dical	d			
H	Box (s iaw requires that the death certifi has been signed by the attending e 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deli	very Day Year
	0	the dea y the at iched fo	ysici	1 □ Pes 2 ☑ No 9 □ Unknown 5 □ Other (specify) □ □ Unknown		Mona	Day Teal
	S, P.	res that igned b be deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recultation C. DIFF Colings		co use contribute to	10
	corc	w requii been s should	leted	CORONARY DIRTERY DISEASE	1 L Yes	2 No 3 Pro	
	l Re	The ate pag	Comp	Systemic Lupus Erythematosus	autopsy performed 1 Tes 2	d? I death?	topsy findings available completion of cause of 2 No
	Vita	Physiclan: The rthis certificate ral director, pag	Be	examiner? Hespital: Other:	th (Check only one)		
	n of	ng Phy fter this neral di	n:Tc	1 Yes 2 No Poshia. 1 Inpatient 2 ER/Outpatient 3 DOA Outer. 4 Nursing Hot 27. Manner of Death (Month, Day, Year) 28b. Time of Injury Work?	28d. Describe how i	e 6 ☐ Other (Specinjury occurred	ofy)
	Division of Vital Records,	Attending r death. sctor: After by the funer	icatio	2 Accident investigation M 1 Yes 2 No	28f. Location (Stree	et and Number or Ru	ral Route Number.
	Ξ	tal or A rs after al Directed in b	Certification: To	3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	State)	
(To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	e, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
(ソ	To the within 2 To the complete	Me	29b. Signature and tille of certifier 29c. License number	29d.	Date signed (Month	n, Day, Year)
•)			30 Name and address of person who completed cause of death (Item 23a) (Type, Print) COOD Som QI	21800 0	10/30/	MD
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COOD STATE OF RAVE	en Bino	BACAM	exe 21739
		Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COOD Som at DR. OKTAM MAMED V 5601 LOCH RAVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 2 2009 Annual States of Death (Item 23a) (Type, Print) COOD Som at DR. CO			

			For State Registrar	State of Marylan	d / Depa	artment of I	Health and M Death	lental Hy	giene Reg. No. 200	9 36186
	Physic		1. Decedent's Name (First, Middle, Las Gloria J.	Bowles				2. Date of De	Dav Year	mat 11. 17.14
5	/Medi Exami		4a. Facility Name (If not institution, give	pict Ball	imare	Baltin	or Location of Death		4c. County of De	ath
610mi	Funeral Director		5. Social Security Number 212-60-3392 1 Usual Residence of Decedent	ex 7. Age (In yrs. 56	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 04/02/	71953 S.	rthplace (State or Foreign Country) Carolina
	ith the Maryland or 28a-f show	tor	10a. State MD N/A	10c. Cit	y, Town or Lo Balt					10d. Inside City Limits 1 □ Yes 2 □ No
(23)	with the 3a or 28a	I Director	10e. Street and Number 5822 Reisterst	own Road		10f. Zip Code	1215		10g. Citizen of What C	ountry?
Bowl	IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Medical Eventure must be notified at	by Funeral	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2€ No If Yes, Give Year or Dates:	1	Was Decedent of Information of Info	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh Specify: B	te, etc.
1005.	Maryland 21215-0036 td 2 should be filed within 72 hours aft tilth and Mental Hygiene. 27 Is marked other than "natural", or r traumatic event, the Medical Event	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+) Years	(Give life. L	dent's Usual Occup kind of work done DO NOT use retire	during most of work d)	ing	16b. Kind of Business	
rough	Taryland 212. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Italy	To Be Co	17. Father's Name (First, Middle, Last) Thomas	Bowles				e (First, Middle,	, Maiden Surname) Hillian	-
3	'e, Maryla 1 and 2 should I Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship (1 Darrell Bowles						oer, City or Town, State, S.Caroli	
Just gait	Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Jos	seph ^{cre} l d Crei	sition (Name of Patory or other pla BYOWN T Natory	^ም Ή 11/1	0 / 0 9		e, Maryland
Jest !	Ball permit Depart Import any in		21. Signature of Funeral Service Licen	V. William	$n = \frac{22}{J}$	Name and Address Name and Name a	ess of Facility • Brown Fulton A	Jr. Fu ve., F	uneral Ho Balto., M	me D 21217
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or companies shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	er the mode of dyi	ng, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
-	BOX 68/6U, eath certificate be executed attending physician and for use as the burial-transit	dical	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequence of pregnation of	ancy _				23d. Date of d	elivery
(that the death cerl hed by the attendin	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		Ectopic pregnand Other (specify)	cy 	91	Month	Day Year
	COTGS, I w requires the sbeen signed should be de	হ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.		tobacco use contribute Yes 2 ☐ No 3 ☐ I	
	The la ate has bage 2	Completed						24a. Was autoj perfo 1 □Yes	ormed? death?	autopsy findings available completion of cause of
	OT VITA Physician: this certificial director, partitions	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatier	nt 3 □ DOA Oth	26. Place of Death		one) idence 6 □ Other <i>(Sp</i>	pecify)
	nding Phath. T: After the funeral	ation: 1	27. Manner of Death 1 Manual 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ry at k? lYes 2 □ No	28d. Describe	how injury occurred	
	= 5 th the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre ý)	eet, factory, office		28f. Location (City or To	Street and Number or I wn, State)	Rural Route Number,
Ú.	the Hospital hin 24 hours the Funeral mpletely filled	edical	29a. Certifier (Check only one) Certifying Ph Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death occur	red at the time,	, date and place, and du	as stated. ue to the cause(s)
	To 1	Σ	29b. Signature and title of certifier	as Cir		29c. Licens	55119		November 29d. Date signed (Mon	
			30. Name and address of person who of Thomas Genu	completed cause of death (Item	23a) (Type,	Print)	f Best	inore		,
	Sta Registi		31. Date filed (Month, Day, Year)	completed cause of death (Iten	ture A.	parkel				

State of Maryland / Department of Health and Mental Hygiene 36187 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October 29, 2009 **Physician** 1:05 P Betsy Brewer /Medical a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner 3144 Gracefield Road; Gardenview 425 Silver Spring Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🔯 F Months Days Hours 564-01-8828 Mar 7, **Director** 1918 North Dakota Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Modical Examiner must confolling at Director 1 □Yes 2√□No MD Montgomery Silver Spring filed within 72 hours after death with the I Hygiene. uther than "natural", or items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3144 Gracefield Road \$425 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: Specify Specify: white à 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event 12 0 dental assistant healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carolyn Jane Eddy Lewis Allen Felger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Eddy Brewer/son 13125 Clifton Road Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Se vi Licensee S, Wade, Director 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate use (Final disease or coultion resulting in death) Physician Metastatic Cancer /Medical Due to (or as a consequence of): Examiner 5 Squantiary list considers, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 sign be icate has been si , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Physician: The certificate 1 ☐ Yes 2 No 1 Yes 2 No : After this certification of the thick of t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural n 24 hours after death.

In Funeral Director: Af pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D59524 Loveen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN J. PUTHUMANA, 3110 GRACEFIELD ROAD, SILVER SPRING, MD 20904 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Bartnisky Ina Jean 2:55 PM November 8,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Dunda1k 826 Jeanette Avenue If Under 1 Year | If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 □ M 2 ₽ F 225-30-7415 **Director** 27,1927 81 Virginia Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Dunda1k 1 ☐ Yes 2X No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene.

Important: If then 27 is marked other than "natural", or items 23a or 2, any injury or other traumatic event, the Medical Exempton 2000. United States by Funeral 826 Jeanette Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cora Stanley ၉ Edward Bolling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda C. Sabol (Daughter) 828 Jeanette Ave. Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Surial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) 11/14/2009 Baltimore, Maryland Gdns of Faith Cem. ure of Funeral Service Licenses 21. Sign 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a Part 1 Enter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on explicit. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Hocers **Physician** 10sselle /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>6</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performe 2 No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0014221 2236 BLAS COL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month. Day. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 36189 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alberta Marie Brown <u>2</u>00 9 10:40AM Nov Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 1 F Days Hours Min. 83 11-9-1925 Director Yrs 220-14-9866 MD Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Essex MD Baltimore 1 🛛 Yes 2 🗌 No 10e. Street and Number ö 10f. Zip Code 2 should be filed within 72 hours after death with the th and Mental Hygiene.
27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? Funeral USA 304 Margaret Avenue 21221 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 XNo þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 ₺ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Berends Emma Moulsdale 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Calgary Ct., Randallstown, MD 21133 Marlene M. Lewy - Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11-10-09 Baltimore, MD 21. Signature of Fundamental Survivo 22. Name and Address of Facility Bradley-Ashton Funeral TURALA 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ a Chanic antruct disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin sician and burial-tran resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical that the death certificate be Jrown, Alverta Records, P.O. Box 6871 nding p IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ortera alsease 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) P 1 🔲 Yes 2 **Z**No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) this completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

XHULL

Towsontown

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Lawrence William Burns NOV 2009 10:30a M 10, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 801 Lee Avenue Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1√2 M 2□ F 214-40-8849 69 MD April 18 1940 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examinating at MD Sykesville 1 Yes 2 No Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with lealth and Mental Hygiene. 21784 USA 801 Lee Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 27 No
If Yes, GiveA Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ white 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) analyst Dept of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Burns Agnes Miedgenowski ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Mary E. Burns (spouse) 801 Lee Ave., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial | 11-14-09 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paigr Jarght D P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IN /Medical Due to (or -s a consequence of): **Examiner** C S anc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page performed Division of Vital 1∐Yes 2⊠No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) moJonathan Day 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	partment of l e <i>rtificate of</i>			iene 200	9 36191			
			1. Decedent's Name (First, M	fiddle, Last)				2. Date of Deat	h	3. Time of Death			
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- N	Examir		4a. Facility Name (If not instit	tution, give street and number	er)	4b. City, Town,	or Location of Death		4c. County of De				
and the				VAL MEDICAL	CENTER	_1	THESDA			TGOMERY			
В	Funeral Director		5. Social Security Number 024–12–8626	1 □ M 21x F	Age (In yrs. last birthda 87 Yrs.	Months Days		8. Date of Birth (Month, Day, July 23, 1	922 Ma	irthplace (State or Foreign Country) Lne			
	/land		Usual Residence of Deceden 10a. State 10b. Con		10c. City, Town or	ocation				10d. Inside City Limits			
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	or 28	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What 0	Country?			
	ath wi	<u>ra</u>	11125 Seven I	Locks Road		20854		τ	Jnited Sta	ites			
Maryland 21215-0036	e filed within 72 hours after death with at Hygiene. other than "natural", or items 23a or other than "natural", or items 23a or other than "natural", or items 23a or other than "natural".	by Funeral	11. Marital Status 1 □ Never Married 2□ 3 ☑ Widowed 4 □ Divo	If Yes Give	No	. Was Decedent of If Yes, specify Cub 1 □ Yes 2 ☑ No	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, lite, etc. Thite			
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121	within ene. than "	Completed by	Elementary/Secondary (0-1		9F 5+)	DO NOT use retire maker	during most of work ed)	9	Own Home				
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ary	shou and N s mar umat		19a. Informant's Name/Relat		19b. Mai	ling Address (Street	t and Number or Run		City or Town, State	, Zip Code)			
	and 2	1	Linda B. Hans	on/Daughter	i					and 20854			
ore	of He		20a. Method of Disposition	ion 3 ☐ Removal from Stat	20b. Place of Disposemetery, cr	oosition (Name of ematory or other pla	ice)		20c. Location - City of	or Town, State			
Ë	. Рад tment tant; I jury o		4 □ Donation 5 □ Othe	er (Specify)	re	ational Ceme	Lamiar		rlington,	Virginia			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, It we wore once."		21. Signature of Funeral Sen	vice Licensee			ess of Facility Phrey Funera gomery Avenu						
			23a. Part 1. Enter the disease shock, or heart failure.	e, or complications that caus List only one cause on each						Approximate Interval Between			
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	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of):								
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.O. Box	Hospital or Attending Physician: The law requires that the death certific 24 hours after death. Funeral Director: After this certificate has been signed by the attending p xiely filled in by the funeral director, page 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birtr	n 2□Fetal death 3 t at time of death 5	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of d Month	lelivery Day Year			
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Records,	he law re e has be age 2 sho	Completed						24a. Was an autopsy perform	/ prior to ned? death	autopsy findings available o completion of cause of			
of Vital	an: T	Be C	25. Was case referred to med	dical			26. Place of Death			es 2 No			
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n o	ding Physician: The In. After this certificate har funeral director, page	[:i	27. Manner of Death 1	28a. Date of Ir	njury 28b. Time Day, Year) Injury	of 28c. Inju	ry at	28d. Describe ho					
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the funeral brown and the funeral brown.	Medical C	29a. Certifier 1. Certi (Check only one) 2 Medi	ifying Physician: To the besical Examiner: On the basis and manner	of examination and/or	ath occurred at the t nvestigation, in my	ime, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)			
	Fo the within 2 Fo the comple	Me	29b. Signature and little of cer		oratou.	29c. Licens	se number	29	d. Date signed (Mo	nth, Day, Year)			
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		ŀ	30. Name and address of pers	son who completed cause of	f death (Item 23a) (Type		ATIONAL N						
0			PETER Z. MCI	NTYRE LT MO	USN	В	ETHESDA M						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36192 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 200^{Year} Allan Baker 6:30 p. M Eugene Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y Months Days Hours Min. Director 083-32-2227 81 1928 Kansas Aug. Usual Besidence of Decedent 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11106 Whisperwood Lane 20852 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Se Yes 2 No 1951-Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White and Mental Hygiene.

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Chesapeake Crematory 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Beltsville, Maryland 22. Name and Address of Facility Rapp Funeral & Cremation Service Signature of Funeral Service ticonsee M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (ur as a curresquence of) executed signed by the attending physician and debetached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant a Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 은 fter this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew M. Leonard, M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

NOV 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			1 - State Registrar	Cer	tificate of	Death	Reg. No	2003	30133
	Physici	an	1. Decedent's Name (First, Middle, Last)			2.	Date of Death Month Da	ay Year	3. Time of Death
- 1	/Medio		<u>Linda Moore Baig</u>				Jovembo		7 11:05 AM
	Examir	er	4a. Facility Name (If not institution, give street and number) FMNKIIN SAMARE HOS	: bital	4b. City, Town, o	or Location of Death	40	c. County of Death	M-1-0
-	Funeral			ns. last birthday)	If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign
	Director		218-42-4067 1□M 2\(\frac{1}{2}\)F	63 Yrs.	Months Days	Hours Min.	(Month, Day, Year, Aug 24,		orth Carolin
	D >		Usual Residence of Decedent	City, Town or Loc					
	laryla shov	5		,	cation				10d. Inside City Limits 1 □ Yes 2 No
	288-1	Director	MD Baltimore 10e. Street and Number	Essex	10f. Zip Code		10g C	itizen of What Cour	
:	3a or		14 Tack Ct.		2122	21		United S	·
į.	death	Funeral	11 Marital Status 12. Was Decedent Ever in	U.S. 13. V		 Hispanic Origin? (Specif an, Mexican, Puerto Ric		14. Race - Americ	can Indian,
98	after or ite	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. Give		i res, specify Cub I⊡Yes 2150No	Specify:	an, etc.)	Black, White, Specify:	etc.
8	hours ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						White
21215-0036	to filed within 72 hours after death with the Maryland to Hygiene. d other than "natural", or items 23a or 28a-f show event, the trained Exemple and the mailtied at	Completed	15. Decedent's Education (Specify only highest grade completed)	i (Give I	lent's Usual Occu _l <i>kind of work done</i> DO NOT use retire	during most of working	16b. F	Kind of Business/In	dustry
212	y with giene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)		gal Secre	•		Law Firm	
פ	e filec al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)		,	18. Mother's Name (F			
<u>X</u>	ould b Ment arked atic e	2	Jackson Posey Moore			Margare	t Vernon		
Maryland	2 sho 2 and is m raum		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	g Address (Street	and Number or Rural R	Route Number, City	or Town, State, Zip	o Code)
e, _	es 1 and 2 and 2 to Health a item 27 is cother trau		Arshad Baig /Husband 20a. Method of Disposition 20b	1.4 D. Place of Dispos		. Essex, MD		Location - City or To	our Chaha
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Invited Examiner must be notified at once.		1 ☐ Burial 2 Cremation 3 ☐ Removal from State	cemetery, crem	natory or other pla	ce) N	10v 07,	,	,
i ii	nit. Pa artme ortani injury	l S	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		ake Crem		.005		e, Maryland
B	Depar Impo any ir	()	J. O. S. R. R.	143		ton and Funer een Pastures			and 21286
			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente				rson naryr	Approximate Interval Between
P	hysician	1	Immediate Cause (Final disease or condition	FOC	ephal	abathu		3	Onset and Death
	/Medical		resulting in death) a. Due to (or as a const	equence of):	- 0	9			
	xaminer	Ļ	Sequentially list conditions, b.	ic P	trnes"				
3	ned nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1 .	etoac	docio			
	execunate and al-train	Examiner	that initiated events resulting in death) Last C. Due to (or as a const	1	21045	100515			
68760,	earr ceruilcate be executed attending physician and for use as the burial-transit		d.						
89	ng phy as th	Medical							
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe	jnancy etal death 3□	Ectopic pregnanc	CV		23d. Date of deliv	•
O.	the a	Physician	1 ☐ Yes 2 No 4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify) _			Month	Day Year
٦.	signed by the a	Phy	Part II. Other significant conditions contributing to death but not re	esulting in the un	nderlving cause giv	ven in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
ds,	ulles n sign ld be	d by		J	, , ,		1 ☐ Yes 2	2 □ No 3 □ Prol	bably 4 🞢 Unknown
Records,	s been si	Completed					24a. Was an	24b. Were auto	opsy findings available
e $\frac{1}{2}$	te has	omp					autopsy performed?	prior to co death?	empletion of cause of
Vital	rtifica tor, p	a	25. Was case referred to medical			26. Place of Death (C	1 □ Yes 2 🔼 N Check only one)	o 1 □Yes	2 LIN0
)	his ce	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2	☐ ER/Outpatient	t 3 DOA Oth	ner: 4 Nursing Home	5 Residence	6 ☐Other (Speci	fy)
Division of Vital Records, P.O. Bo	After t	iuo	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury	28c. Inju Wor		l. Describe how inju	iry occurred	
Sic	death death stor: /	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	homo form etre		Yes 2 □No	Location (Caract	and Number of Due	al Bauta Mumba
<u> </u>	after Direct Direct	Certification: To	4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	city)	et, lactory, office	201.	City or Town, Stat	and Number or Rura te)	ai Houte Number,
china	hours neral y filler		29a, Certifier 1 Certifying Physician: To the best of my k	(nowledge, death	occurred at the ti	ime, date and place, and	d due to the cause(s) and manner as	stated.
4	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	(Check only 2 Medical Examiner: On the basis of examiner) and manner stated.	ination and/or inv	estigation, in my	opinion, death occurred	at the time, date ar	nd place, and due to	o the cause(s)
Ę	To t	Σ	29b. Signature and fittle of certifier	1,->	29c. Licens	se number	29d. Da	ate signed (Month,	Day, Year)
			· (XVVVX) SIM	166	145	4867	((12/6	7
			30. Name and address of person who completed cause of death (It	-	Print)	quere Dr	Roll.	MA MI	521237
	Sta	te.	31. Date filed (Month, Day, Year) 32 Registrar's Sig		THIN J'	voic VI	Dul / M	raic 1	
	Registr		NOV 1 2 2009 Jenn	A. Sa	RED				

		1	For State Registrar		State of Ma	aryland	l / Depa <i>Cer</i>	artment of F <i>tificate of L</i>	lealth and I Death	Mental Hyç ı	giene Reg. No	2009	36194
Phys		/	Decedent's Name (First	0	ARBER					2. Date of Dea Month		v Year	3. Time of Death
The state of the s	edica mine	4	a. Facility Name (if not in.		street and number)			_	Location of Death	1 /1	4c.	. County of Death	
Fune	_		Social Security Number 219–12–58	6. Se		(In yrs. las 97	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	h	9. Birth 1911 OM	place (State or Foreign
Direct		_	sual Residence of Dece	dent			Yrs.			Dec	.027,		
Maryland :8a-f show tiffed at			0a. State 10b.	County Balti	more	-	Town or Loc ockey	sville					10d. Inside City Limits 1 ☐ Yes 2 ☐No
ith the N 23a or 2 st be no		<u> </u>	0e. Street and Number	ind Roa	d		-	10f. Zip Code 2103	30		_	tizen of What Cou	ntry?
death w			1. Marital Status		12. Was Decedent Ev Armed Forces?			Vas Decedent of Hi Yes, specify Cuba				S.A. 14. Race - Americ Black, White,	
0036 urs after ural", or	4	len by	1 Never Married 2 3 Widowed 4 C	Divorced	1 ☐ Yes 2.★↑ If Yes, Give Year or Dates.	To .	1	☐ Yes 2 No	Specify:			Specify:	Black
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. 2 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	Polarico			Decedent's Ed nly highest grad (0-12)			(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired)		king		ind of Business In	
Id 21 Ild with Hygien other #	200	1	7. Father's Name (First, A				Fa:	rmer	18. Mother's Nan	ne (First, Middle, I		Agricult Surname)	ure
Maryland should be filed and Mental Hy ris marked oth	Ę	-	Charles	Barber	2				Annie	e Unk			
> 2577		Ľ	9a. Informant's Name/Re Brigitte	Maneki.	n / Frien	d	19b. Mailin 22	g Address (Street a 9 Ashlan	and Number or Run d Road C	ral Route Number, ockeysvi	; City or 11e	Town, State, Zip (, MD 210	30 (Code)
Baltimore, I permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		21	Da. Method of Disposition 1 Burial 2 Cre 4 Donation 5	mation 3 🗆 I		cen	netery, crem	sition (Name of eatory or other place eake Crem			,	ocation - City or To Ltsvill	
Baltil Dermit. F Departm Importal	ouce.	2	1. Signature of Funeral S			443	22.	Nam and A	100 tot		tern	atives	land 21286
		2	3a. Part 1. Enter the dise	ease, or complete. List only one	ications that caused e cause on each line.	the death.	Do not ente					John Mary	Approximate Interval Between
∼Ph√sicia / Medic		0	mmediate Cause (Final lisease or condition esulting in death)	- Total	a. Due to (or as a			DEMER	ITIA.				Onset and Death
Examin	•		Sequentially list condition	ns,	o. 								
uted nd ransit	Examiner	o d	tany, leading to immedia cause. Enter Underlying Cause (Disease or iinjury hat initiated events	`	Due to (or as a	conseller	nce oth						
/60 cate be executed physician and s the burial-transit	edical E	ľ	esulting in death) Last		Due to (or as a	consequer	nce of):						
certificate b certificate b anding physical			FEMALE:	. 2	3c. If yes, outcome o	f pregnanc	v				Т		
. BOX In the death of the attentiched for us	Physician/M	23	Bb. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	arit I		Fetal d	leath 3 🗌	Ectopic pregnance Other (specify)	у			23d. Date of delive Month	ery Day Year
equires that the death cen signed by the atternould be detached for	۾		art II. Other significant o	conditions cor	ntributing to death bu	t not result	ing in the ur	nderlying cause giv	en in Part I.				ne cause of death? bably 4 📈 Unknown
Ittal Hecords, P.O. Box 68, sician: The law equires that the death certific certificate has teen signed by the attending rector, page 2 should be detached for use as	Completed	-								24a. Was a autops perfor 1 Yes	sy med?	prior to co death?	psy findings available mpletion of cause of
VITAI P ysician: T ysician: T ysician: T ysician: T	Be C	25	i. Was case referred to mexaminer?	_	ospital:			Othe	ice of Death (Chec	k only one)			
I OT V ing Phys fter this uneral di	ate: To		. Manner of Death	Pending	1 Inpatier 28a. Date of injury (Month, Day,	28	3/Outpatient 3b. Time of injury	3 L DOA 28c. Injury	440 Nursing Ho	ome 5 Reside 28d. Describe ho		Other (Specify occurred)
UNISION OF VITAI HECO To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificale has it completed filled in by the funeral director, page 2 s	Certificate:		2 Accident	Investigation Could not be determined	28e. Place of Injury building, etc.	/ - At home	e, farm, stre		Yes 2 □ No			d Number or Rural	Route Number,
spital or nours aff neral Dir	ical		9a. Certifier 1 ☐ Ce	rtifying Physic	cian: To the best of m		ge, death or	ccured at the time.	date and place, ar	City or Town			d.
the Ho ithin 24 I the Fu	Medical		(Check 2 Me	dical Examine rtifying Nurse		mination ar	nd/or investig	gation, in my opinio	n, death occurred a time, date and place	t the time, date an	d place, cause(s)	and due to the car and manner as st	use(s) and manner stated. ated.
F > F 8									02S9		.au. Date	e signed (Month, I	Day, 16di)
		30	Name and address of p	person who co	mpleted cause of dea			Valley	Rd. In	ithervi	116	MD	
S Regis	state strar	31	. Date filed (Month, Day,		32 Registrar	s Signature	Ba	Alas		· ····································	116	,	
					-	1-	1 11						

State of Maryland / Department of Health and Mental Hygiene 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Box 68760,		Baltimore, Maryland 21215-0036
l or Attending Physician: The law requires that the death certificate be executed after death.	Phy /M Exa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene.
I Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	sicia edic imin	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

	-	1 - State Registrar	Ce	rtificate of D	eath	Reg. No. 2009 36195								
		1. Decedent's Name (First, Middle, Last)				2. Date of Death	Month Day Year							
Physici /Medio		Joyce L. Billones				November	4 2009	11:00 BM						
Examin	- 4	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I			4c. County of Death							
	Ser.	6654 Roberts Ct. Apt. 12	3		Burnie		A.A.							
Funeral			rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes	9. Birth	place (State or Foreign intry)						
Director		219-52-3199 1□M 2XF	61 Yrs.			Jun 13,		rth Carolina						
] }	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits						
shov	=	100.000						1 ☐ Yes 2 No						
28a-f otiffe	Director	MD Anne Arundel	Glen B	10f. Zip Code		100	Citizen of What Cou	intry?						
a or 2		10e. Street and Number				109.	United S	i						
s 23	Funeral	6654 Roberts Ct. Apt. 123	11S 13	Was Decedent of His		ecify Yes or No-	14. Race - Amer							
item	Š	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married		Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, White	, etc.						
ii", or	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White						
atura cai E		15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion		. Kind of Business/I	ndustry						
n 'n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	e kind of work done do DO NOT use retired)	uring most of work	ing								
ir tha	E	10	Но	memaker			Own Home							
othe vent,	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Maid	den Surname)							
Aenta rked tic e	은	Calvin Stilley			France	s Parker								
s ma		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street a	nd Number or Rur	al Route Number, Ci	ty or Town, State, Z	ip Code)						
alth alth 27 le er tra		Amy Frondoso /Daughter	81	.07 Dewber	ry Circle	Pasadena, MD 21122 Date 20c. Location - City or Town, State								
item item			 Place of Disposers cemetery, cre 	osition (Name of ematory or other place	e) ¦	Nov 05,	. Location - City or	own, State						
nt: #		1 ★Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify)	Holy Cr	coss		2009	Brooklyn,	Maryland						
perint. I ago I lank and Mental Hygiene. Important if item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee												
a m m		8717 Green Pastures Drive Towson Maryland 21286												
or M		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
hysician	0.7	shock, or heart failure. List only one cause on each line. Immediate Cause (Final Charlet Cha												
/Medical					70913									
xaminer		Due to (or as a comaguence of):												
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):												
id ansit	Examiner	Cause (Disease or injury												
an ar rial-t		resulting in death) Last Due to (or as a con	sequence of):											
physician and the burial-transit	Medical	d												
ව ගි	Ned	IF FEMALE:												
endii		23b. Was decedent pregnant 23c. If yes, outcome pripre		☐Ectopic pregnancy			23d. Date of delivery Month Day Year							
ne att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time		Other (specify)			WOTH	Day Teal						
by the	Physician/	9 Unknown												
gned gned	by	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause give	en in Part I.			the cause of death?						
equil en si ould l						1 Tes	2☑No 3□Pr	obably 4 Unknown						
as be 2 sh	ple					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of						
ate h	Completed					performed	death? No 1 ☐ Yes	2 □ No						
ertifica ctor,	Be	25. Was case referred to medical examiner?				th (Check only one)								
his ce I dire	70		2 ☐ ER/Outpatie		4 1 Muising in	ome 5 Residenc	e 6 ☐Other (Spec	oify)						
fter there		27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Yea	28b. Time (of 28c. Injury Work	at c?	28d. Describe how	injury occurred							
or: A	atic	2 Accident investigation			Yes 2 □ No									
irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - i building, etc. (St	At home, farm, s ec <i>ify)</i>	treet, factory, office		28f. Location (Stree City or Town, S		ral Houte Number,						
irs af				u a a a da a da a da a da a da a da a d			()							
within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check only one) 2 Medical Examiner: On the basis of examiner stated.	nination and/or i	ith occurred at the tin investigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	e and place, and due	to the cause(s)						
thin 2 the mple	Med	one) and manner stated. 29b. Signature and title of ceffifier		29c. License	e number	29d.	Date signed (Mont	h, Day, Year)						
1	_	290. Signature and integrit continued		100										
		har han	m	الالا	U0 74	/ / V	ovem uch	7,0001						
		30. Name and address of person who completed cause of death	(Item 23a) (Type	Print)	- Gla	- River	IP MA	4,2009 D-21061						
		31. Date filed (Month, Day, Year) 32. Registrar's S	INU>DI	tal U	. 010	n Duin	10/10/	0.01001						
Sta Regist	ate rar	NOV 1 2 2009	A A	No. of Contract of										
ricgist	rui	1101 = 2003 Chrus	A Badel											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 36196 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Month -Day **Physician** 7 2009 Hopkins Bixler 8:00 A M Kathryn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Lutheran Village Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9(Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2 🗓 F 92 219-34-2337 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Carroll Westminster 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 1233 Emerald Ridge Dr. USA Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>ک</u> Specify: white 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Banking permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other th any injury or other traumatic event, the onee. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Hopkins Fannie Babylon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelbia Markley-daughter 1233 Emerald Ridge Dr., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadow Branch Cem. 11-11-09 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home homos 254 E. Main St., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onșet and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weer /Medical Due to (or as a consequence of): **Examiner** V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 **N**o To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 6 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

4ACKS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

-91 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

52035

29d. Date signed (Month, Day, Year)

2009

			For State Registrar		State of Ma	aryland / I	Depa <i>Cer</i>	rtment of F <i>tificate of I</i>	lealth and N Death	lental Hy	gien	e 2009	36197
			1. Decedent's Nam	e (First, Middle, La	nst)		-			2. Date of De	eath		3. Time of Death
1	Physici /Medio				Beasley					Octob	er	29,200	
	Examir	ier			ve street and number)	Cont	0.70		r Location of Death			c. County of Dear	
	Funeral	г	5. Social Security N	lumber 6.		e (In yrs. last bi		Cheve If Under 1 Year	if Under 24 Hrs.	8. Date of Bi	rth	rince G	thplace (State or Foreign
	Director		578-40-	6394	1□M 2 X F	90	Yrs.	Months Days	Hours Min.	March	24	,1919 s	Shipman, VA
	land ow		Usual Residence o	10b. County		10c. City, Tow	n or Loc	cation					10d. Inside City Limits
	a-f sh	ctor	MD	Prince	Georges		Noi	th Bren	ntwood				1 XXYes 2 □ No
	ith the	Director	10e. Street and Nu		_			10f. Zip Code			10g. (Citizen of What Co	ountry?
	eath w	Funeral	3915 Wa	llace R	oad 12. Was Decedent I	Ever in LLS	12 1/		722	coify Vos or N	2	USA 14. Race - Ame	origan Indian
တ	or item		11. Marital Status 1 ☐ Never Marr	ied 2☐ Married	Armed Forces? 1 ☐ Yes 2 🛣				lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.))-	Black, White	e, etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiror must be redified at	d by	3 XWidowed	4 Divorced	If Yes, Give Year or Dates:		1	□Yes 2 XNo	Specify:			Specify: B	Lack
<u>.</u>	n 72 h i "natu valice	Completed		15. Decedent's E cify only highest gr	ade completed)		Give I	ent's Usual Occup kind of work done o	ation during most of work d)	ing	16b.	Kind of Business/	/Industry
212	d withi	mo	Elementary/Second 12t		College (1-4or 5	+)		lerk	•/		Fee	deral G	overnment
nd	be filed tal Hy d othe event,	Be	17. Father's Name	(First, Middle, Last)				18. Mother's Name	e (First, Middle	, Maide	en Surname)	
<u>∑</u>	를 출 <mark>중</mark> 등	မ		iam Bea								addock	
Z	07 = 70 3		19a. Informant's N	•	/Daughte:	r-in-T.	o. Mailin	4305 S	and Number or Rur table M MD		oer, City Our	t or Town, State, 2 t	Zip Code)
ē,	iter oth		20a. Method of Dis	position		20b. Place o	of Dispos	sition (Name of patory or other place	<u>PID</u> [20 / 20 Date		Location - City or	
Ĕ	Pages ment of ant: If it			☐ Cremation 3 L 5 ☐ Other (Speci	Removal from State		Lin	coln Ce	m. 11/	6/09	Bre	entwood	, MD
Baltimore, Maryland	permit. Page Department (Important: If any injury or once.		21. Signature of Fu	ineral Service Lice	/// >	2225							eral Servic on,DC 20011
	10100		23a, Part 1, Enter t	he disease, or com	plications that caused	00996				<u> </u>		Silling Co	Approximate
V.	Physician	67.	shock, or hea Immediate Cause	iri failure. List only (Final	one cause on each lir	е.				or respiratory t	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	on 🕜		ral Va a consequence		lar Acc	ident				
	Examiner	L	Sequentially list co	nditions.	_{b.} Atrial			tion					
Т	nsit	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	mediaté iriying injury	Due to (or as	a consequence	of):						
.	execun and ial-tra	Exar	that initiated events resulting in death)		C	consequence	of):						
98760	ificate be executed g physician and is the burial-transit	edical			d								
	ertifica ding pl		IF FEMALE:		00- 16								
ROX	e law requires that the death certific has been signed by the attending p to 2 should be detached for use as	Physician/M	23b. Was deceden in the past 12	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)	у			23d. Date of de Month	livery Day Year
г. Э	t the d by the ached	hysi	1 □ Yes 2 [9 □ Unknown		9 Unknown								
Š,	law requires that the as been signed by the 2 should be detache	by P			contributing to death bu				en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
0	requir	ted	Acute	Renai Fa	ailure, C	ardion	пуор	patny		1 🗆	Yes	2 ☐ No 3 ☐ Pi	robably 4 XUnknown
Vital Records,	has b	Completed								24a. Was		prior to	utopsy findings available completion of cause of
la I	in: The tifficate or, page	ပ္ပ	25. Was case refer	red to medical					OC Place of Docat	1 □ Yes	2 X N		2 □No
<u> </u>	tysicia lis cer direct	To B	examiner?	_	Hospital:	nt 2 ☐ ER/Ou	utpatient	3 □ DOA Othe	26. Place of Deatler: 4 □ Nursing Ho			6 ☐Other (Spe	ecify)
0	ing Ph (fter th Ineral	L:uo	27. Manner of Deat	h 5 🗌 Pending	28a. Date of Inju (Month, Day	y 28b.	Time of Injury	28c. Injury Work		28d. Describe			
<u>S10</u>	ttendi Jeath. tor: A the fu	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not b				M 1 🗆	Yes 2 □No		_		
DIVISION OF	I or A	Certification:	4 ☐ Homicide	determined		. (Specify)	ırm, stre	et, factory, office		28f. Location (City or To	Street a wn, Sta	and Number or Hu te)	ural Route Number,
	ospita hours uneral ly filled		29a. Certifier	1 Certifying PI	nysician: To the best	of my knowledge	e, death	occurred at the tin	ne, date and place,	and due to the	cause	(s) and manner a	s stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical	(Check only one)		miner: On the basis of and manner sta	examination ar ted.	nd/or inv			red at the time,	date a	nd place, and due	e to the cause(s)
	vitt Con	Σ	29b. Signature and		9 5-11:	6		29c. License	67810		29d. E	ate signed (Mont	· '
				keeu	S. Siddig	une	(Times =	you de la constitution de la con	04810	,	10/	30/20	
			30. Name and addr	LEEN S	completed cause of de	U (3	(iype, F	mmt) ∉Hoessi+	al Drive	e.Chev	er.	lv. MD	20785
	Sta		31. Date filed (Mon	th, Day, Year)	completed cause of display 2009 32. Figure 2009	r's Signature	A	Constant of the Constant of th	V	- , O.10 V		-11 -20	
	Registra	ar		MAATO	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene For State Registrar 2009 36198 Certificate of Death Reg. No. 1. Decedent's Name #First 2. Date of Death 3. Time of Death Year **Physician** 200 4.70AM /Medical 4c. County of Death 4b, City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/04/1917 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🕽 F a Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County notified at BALTIMORE 1 ☐ Yes 2 ☑ No MD ROSEDALE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 1233 KAHLER AVENUE 21237 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: Specify WHITE q 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED CHARLIE'S 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN SRAVER ANNIE (DeBELIUS) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is: any injury or other MARGARET ANDERSEN/DAUGHTER 1233 KAHLER AVENUE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 Cremation 3 Removal from State GARDENS OF FAITH 11-11-09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** man A. UK /Medical Due to (or as a consequence of): Examiner MSCI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 1 □ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform 1□ Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred I or Attending Fafter death. Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide the Hospital | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the Funeral 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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CRNP

32. Registrar's Signatur

			1 - For State Registrar	State of Ma	ar yrai io		tificate of L			Reg. No. 2005	36199
	Physicia		1. Decedent's Name (First, Middle, Las	•	Do	T TO S			2. Date of Dea Month Novembe		3. Time of Death 6:54 PM
	Medic Examir		Rennes 4a. Facility Name (if not institution, give	R. street and number)	BC	wman	4b. City, Town, or	r Location of Death	-	4c. County of De	
			Gilchrist					Iowson		Balt	imore
	Funeral Director		<u> </u>	7. Age	e (In yrs. las 63	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day June 6	, Year) 1946 C	irthplace (State or Foreign country) alifornia
	and show dat	١٥	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation			-	10d. Inside City Limits
	Mary 28a-f otifie	Director	Maryland Howard		E11	icott	City				1 ☐ Yes 2 ☐XNo
	th the	a D	10e. Street and Number				10f. Zip Code			10g. Citizen of What 0	
	ath wi	Funeral	7601 Stony Creek	Lane 12. Was Decedent E	ver in IIS	13 W		1043	pecify Yes or No-	U.S.,	
980	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show ed other than matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 😾 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 If Yes, Give 19 Year or Dates.		92 1	Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	14. Race - An Black, Wh Specify:	ite, etc.
9	hours natura lical E	lete	15. Decedent's Ed	ducation		16a. Deced	ent's Usual Occup			16b. Kind of Busines	White s Industry
21215-0036	Specify: Specify Spec										•
	d with Hygier ther t nt, th	Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Financial Consultant Financial 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)									
Maryland	be filed ental Hy ked oth ic event	10	Rennes	R. I	3owmar	1		18. Mother's Nan		Maiden Surname) Hearn	
ary	1 and 2 should be file of Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Ty	Zip Code)							
	0 ± 0 ±		Pamela Bowman	Wife		_4_St	one Manne	er Court	Towson	, Maryland	21204
ore	t of H Hitel or oth		20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐	Removal from State	cer	netery, crem	sition (Name of atory or other plac		Date	20c. Location - City	or Town, State
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		1 Burial 2 X Cremation 3 4 Donation 5 Other (Specify 21. Onal, re of un ervice Licens		Hill			orp. 11-9		Towson	Maryland
Ba	permit Depar Impor any in		21. Sonate of units ervice Licens				Name and Addres	Road 1	ick Tows Towson, 1	on Funeral Maryland	Home, Inc. 21204
П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final	lications that caused ne cause on each line	the death.	Do not enter	the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as a	HOS	5/5					Onset and Death MONTHS
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	7 ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	nce of):					
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3760	ificate ig phy as the	Medical	IE EEMALE.	u.							
39 X	aath certific attending I for use as	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal o	death 3 🗌	Ectopic pregnanc	;y		23d. Date of c	,
Box .	r the al	Physician/N	1 ☐ Yes 2YZONo 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5∐	Other (specify)			Month	Day Year
P.O.	requires that the de been signed by the s should be detached	by Pt	Part II. Other significant conditions co	ntributing to death bu	ut not result	ting in the ur	derlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	quires en sig ould bo	ted t							1/2	Yes 2 No 3 No	Probably 4 🗆 Unknown
of Vital Records,	law has e 2	Completed							24a. Was a		utopsy findings available completion of cause of
- R			25. Was case referred to medical				00.00	and Death (Char	1 🗌 Yes		es 2 No
Vita	ysicial s certi directo	To Be	examiner?	Hospital:	ent 2 🗆 Fi	R/Outpatient	Tothe	er:		lence 6 🔀 Other (Spe	ecify) HOSPICE
n of	Attending Physician: It death. ector: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day	у 2	8b. Time of injury	28c. Injury work	/ at		ow injury occurred	iony) (1
Division	I or Attend safter death Director; / d in by the I	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju		e, farm, stre		ies Z 🗆 No		treet and Number or F	ural Route Number,
Ω̈́	Hospital or 24 hours afte Funeral Dire sted filled in I		1	building, etc					City or Tow		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examin	ner: On the basis of ex	amination a	and/or investi	gation, in my opinio	on, death occurred a	at the time, date a	use(s) and manner as s nd place, and due to the e cause(s) and manner a	e cause(s) and manner stated.
	To the within 2 To the Completed		29b. Signature and title of certifier	20	- 4-		29c. License	number 1395	n	29d. Date signed (Mon	ith, Day, Year)
			30. Name and address of person who co	ompleted cause of de	eath (Item 2	3a) (Type, Pr	int)	010	17	NO VINCE	·WILLI
			30. Name and address of person who con DANIEUE DOBLEN 31. Date filed (Month, Day, Year)	NAM NO B	70/ N	CHAR	UES ST	, SMITE	4105	BALTIMIRE,	ms 21204
	Stat Registra		NOV 1 2 2009	32. Registra	rs Signatur	BONA	es e				

			1 - For Stete Registrar	State of	Maryland	/ Depa	artmen <i>rtificate</i>	t of H e of L	ealth a Death	ınd M		ene2	009		200
	Physici	ian	1. Decedent's Name (First, Middle, La								Date of Death Month	Day	O O Year	3. Time	
-	/Medi		William Edward								November	T	2009	6:15	A M
	Examir	ner	4a. Facility Name (If not institution, give				1		Location of			4c. C	ounty of Death		
			Springwell Nur 5. Social Security Number 6.3		e '. Age (In yrs. last	t hirthday)			If Under 2		8. Date of Birth	<u> </u>	9. Birth	place (State	or Foreian
	Funeral Director			1 √2 M 2□F	85	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, August 24	Year) 1924	H Moge	place (State intry) achuse	
	D		Usual Residence of Decedent									,	11635		
	anylan show	_	10a. State 10b. County		10c. City, T			_						10d. Inside (City Limits s 2 ☐ No
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	vith th	Dire	10e. Street and Number		n+ 103	Foot	10f. Zip	2120	na		10	_	n of What Cou	intry?	
	s 23s	ala	2211 W. Rogers A		lent Ever in U.S.		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			in 2 (Cn	noity Van or No		U.S.A. Race - Ameri	ican Indian	
	ter de Item	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Ford	es?	13.	If Yes, spec	ify Cuba	n, Mexican,	, Puerto	ecify Yes or No- Rican, etc.)	14	Black, White		
336	ars af	by	3 ☐ Widowed 4 ☐ Divorced	1 √ Yes 2 If Yes, Give Year or Da	tes:		1 Yes	2 √ №	Specify:			S	pecify:	White	
21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene marked other then "neturel", or Items 23s or 28e-1 show matic event, the Mudicul Exams per count be conflicted	Completed by Funeral Director	15. Decedent's B	ducation	1	6a. Dece	dent's Usua	I Occupa	ation	-6		16b. Kind	of Business/Ir	ndustry	
218		ple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	kind of wor DO NOT us	se retirea	uring most)	OF WORK	ng			_	4
	er th	Con		4_		Sa	les_						dustri	al	
nd	be file tal Hy d oth eveni	Be	17. Father's Name (First, Middle, Las					5	_		(First, Middle, N		итате)		
Ş	l and 2 steadth ar mm 27 is then treu	မ	Leo F. Brazis							bara					
Maryland															
			William E. Brazis, Jr. / Son 6429 Fairest Dream Lane, Columbia, Maryland 21044												
Baltimore	permit. Pages i Department of H Importent: If ite any injury or ot once.		1 🔀 Burial 2 □ Cremation 3 [tate Dula	etery, cre	matory or o Valley	ther plac 7	θ)		4.40000				nd
臣	it. Partiment intent injury			A. Method of Disposition 1 Strian 2 Cremation 3 Removal from State 1 Strian 2 Cremation 5 Other (Specify) 20b. Place of Disposition (Name of Disposition (Name of Date Crematory, crematory, crematory, crematory, crematory, crematory, crematory, crematory, or other place) 1 1/11/2009 20c. Location - City or Town, State Timonium, Maryland 20s. Signature of Date Control of City or Town, State Timonium, Maryland 20c. Location - City or Town, State Timonium, Maryland 20c. Location - City or Town, State Timonium, Maryland 20c. Location - City or Town, State Timonium, Maryland 20c. Location - City or Town, State Timonium, Maryland 20c. Location - City or Town, State Timonium, Maryland 20c. Location - City or Town, State Timonium, Maryland											
Ba	permi Depar Impo any ir		21. Signature of uneral spivice cice	Fin	22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204										
	_		23a. Part1. Enter the disease, or con	plications that ca	used the death. I					-	, ,				
	B		shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ch line.				•			-		Interval Be Onset and	atween d Death
	Physician /Medical		Onset and Death sease or condition sulfing in death) a. End Stage Demention												
	Examiner			Due to (or as a consequence of):											
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	uted	Examiner	Cause (Disease or injury that initiated events	C											
o,	cate be executed physician and the burial-transit	Ex	resulting in death) Last	C. Due to (or as a consequence of):											
58760,	ite be nysicii ne bu	dlcal	•	_ d											
	ntifica ng ph s as th	Med	IF FEMALE:												
Вох	th ce	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live bir	ome of pregnancy th 2 ☐ Fetal de	ath 3[∃Ectopic pr	egnancy				23	d. Date of deliver Month	ery Day	Year
	e dea the at	sici	1 Yes 2 No	4☐Pregna 9☐ Unknov	nt at time of deati vn	h 5[Other (sp	ecify)					Nontr	Day	Tour
P.0	The law requires that the death certifi ate has been signed by the atlending page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions	contributing to day	ath but not reculting	na in the u	indorhina o	2000 200	on in Part I		23e Did tob	2000 1186	contribute to	the cause of	f death?
S,	ires (t signe	by	his a square distances	- must as	1 A	ldin	* / /	auso give	311 III 1 O.I.C.I.			s 2 🗆			Unknown
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Sec.	elaw hast	ם	Aneupm, at	, Aneu	un						24a. Was ar autops perforn	n Nad2	24b. Were aut prior to co death?	opsy finding ompletion of	cause of
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of Vital	Physicien: this certificant director,	Be	25. Was case referred to medical examiner?	Hospital:				A Othe			(Check only one				
o	Phys this raldii	. To	1 Yes 2 No 27. Manner of Death	1 1 1 1 In	patient 2□ER	VOutpatier 3b. Time o		A	4 ANUI		me 5 🗌 Reside 28d. Describe ho			ify)	
LO O	ding l h. After funer	ţ	1 XNatural 5 ☐ Pending	28a. Date of (Month	, Day Year)	Injury	м	8c. Injun Work	k? Yes 2 □ N		200. 2000.120 110	,,			
Division	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not t	08 Diago (of Injury - At home	a, farm, st	-				28f. Location (Str	eet and i	Number or Rui	al Route Nu	mber,
Β	after after Dire	Certification;	4 Homicide determined	buildin	g, etc. (Specify)						City or Town	, State)			
	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the luneral director, page 2										nd manner as	stated.			
	n 24 l n 24 l ne Fu sletely	Medical	(Check only 2 Medical Exe	miner: On the bas and manne	sis of examination or stated.	and/or in	vestigation,	in my o	oinion, deat	h occurr	ed at the time, da	ite and p	lace, and due	to the cause	(s)
	To the To the Comp	ž	29b. Signature and title of certifier				290	License	number		29	d. Date	signed (Month	Day, Year)	
			R.t. f	besto	MS.			D.2	14 6	X		1/-	- 9-09		
			30. Name and address of person who	completed cause	of death (Item 23	За) (Туре,	Print)								
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DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ye ar **Physician** Borkoski 3100 PM voicenter 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospotal Harber If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yea 7/1/1937 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 XX 2 □ F 72 Months Days Hours Director MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location show "natural", or items 23a or 28a-f shor N/A MD Baltimore Director 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1223 Haubert Street 21230 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, Ite Medical Examina 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 N Married 2 X No Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify white Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n Manufacturing Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be John J. Borkoski, Sr. Margaret Peterson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1223 Haubert Street, Baltimore MD 21230 19a. Informant's Name/Relationship (Type. Print) Janet L. Borkoski / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Ardent Crematory 11/14/2009 Hanover MD 4 ☐ Donation 5 ☐ Other (Specify) Doda, Jr²². Name and Address of Facility 21. Signal we of Fune all Service Licensee $Victor\ P_{ullet}$ Charles L. Stevens Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a specific or respiratory arrest,

Immediate Cause (Final Inc.) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatu COM 0, disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar has autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: '24 hours after death, Funeral Director: After this certifica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year, State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Dout 901 E. Fort We., Baltimore, MD 32. Registrar's Signature

CUN

ORIGINAL

29c. License number

D396660

29d. Date signed (Month, Day, Year) November 10, 2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19b, perFH, G897, 11717/09, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 36202 Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 100 vember 12:50AM Medical 4a Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death altimore atonsvill 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 6. Sex 9. Birthplace (State or Foreign Carolina Hours 1 □ M 3/E Director Usual Residence of Decedent items 23a or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 Yes 2 No MD atonsv 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 within 72 hours after death with Frederick 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Yes 2 No If Yes, Give Black, White, etc. o 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Black should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Widowed 4 □ Divorced Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ tician HOSpita ath Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ဥ illiams 19a. Informant's Name/Relationship (Type. R 19b. Mailing Addres Shadows Rural Route Number, City or Town, State, Zip Code) Shaw permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra iatonsville, MD alaab mertine 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Zion ansdowne, mo 21. Signature Funeral ass Bal Home P. A. the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line Approximate Interval Between use (Final Onset and Death Immediate C Physician. disease or condition Medical resulting in death) Due to (onsequence of) Examiner Sequentially list conditions ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months2 Month Day Year 1 Yes 2 Unknown ı signed by the a Id be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown has been sig ge 2 should b 1 Tes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐ Yes 2 🗷 No Yes 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🍕 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 🗘 rtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Near) 30. Name and address/of person who completed cause of death (Item 23a) (Type, Print) Who val LA 31. Date filed (Month, Day, 32. Registrar's Signature State NOV 1 & ZUUS Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1	Physicia /Medic Examin	al
	Funeral	
	Director	

			State Registrar	C	ertificate of Death	Reg. N	.2009	36203
П	Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death Month D		3. Time of Death
	/Medic		Florence P. Choquette					6:50 A™
100	Examir	ier	4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of De		c. County of Death	
-20			Montgomery General Ho 5. Social Security Number 6. Sex		Olney If Under 1 Year If Under 24 F		ontgomery	e (State or Foreign
	Funeral Director		068-24-2493 Substituting 1	F 81 Yrs	Months Days Hours M		8 New Y	York
	land ow		10a. State 10b. County	10c. City, Town or	Location	·····	10d.	Inside City Limits
	Mary From	to	MD Montgomery		Sandy Sprin	gs		1 □Yes 2 K No
	r 282	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country	?
	th with	ם	17340 Quaker Lane		20860		U.S.A.	
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, i'm Medical Eracifing out by modified at	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. If Forces? es 2 X No , Give or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu □ Yes 2 \(\) \(\) \(\) Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Black, White, etc. Specify: Whit	
ŏ	2 hou	bed	15. Decedent's Education	16a. De	cedent's Usual Occupation	16b.	Kind of Business/Indus	try
21215	J within 72 giene. r than "n.	Completed	(Specify only highest grade completed and the secondary (0-12) Elementary/Secondary (0-12) College 1	je (1-40r5+)	ive kind of work done during most of v e. DO NOT use retired) Secretary		1CA	
Maryland	2 should be filed withir is and Mental Hygiene. is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Edmund Ambrose			lame (First, Middle, Maide McDermott	en Surname)	
2	is all		19a. Informant's Name/Relationship (Type. Print) Edmund Ambrose/Brothe		ailing Address (Street and Number or 9 Woodridge Avenu	-		ode) 20901
	Pages 1 and 2 nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal fit 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Discemetery,	sposition (Name of strematory or other place) emation Services 11	Date 20c.	Location - City or Town	, State
Ħ	- F # - F		21. Signature of Funeral Service Licensee	7 EGGIR G	22. Name and Address of Facility A			
B	Depar Impor any ir		Lama CHardes	to M01197	7522 Connelley Dr			
- Light	Physician		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause	caused the death. Do not			A	pproximate iterval Between nset and Death d.m
	/Medical Examiner	L	Due	2000	Rm		-	2 days
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events c.	to (or as a consequence of):				
68760,	icate be executed physician and the burial-transit	Medical Ex	resulting in death) Last Due	to (or as a consequence of):				
O. Box 6	e death certif he attending ed for use as	Physician/Med	in the past 12 months?	outcome of pregnancy ive birth 2☐ Fetal death regnant at time of death Inknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	9.	23d. Date of delivery Month Da	
s, P.(res that the signed by t be detach	by Phy	Part II. Other significant conditions contributing		e underlying cause given in Part I.		o use contribute to the	
ord	w requir been s should	ted		ad cat		_ 1 ☐ Yes	2 XNo 3 Probab	JIY 4 OIKHOWII
Il Records,	: The law cate has b page 2 sh	Completed	HSDIATION PNEUM	Disenc		24a. Was an — autopsy performed? 1 □Yes 2 2 2	prior to comp death?	y findings available letion of cause of
of Vital	slcian: The certificate rector, pag	Be (25. Was o se referred to medical examiner?			Death (Check only one)		
) JC	Physic this c		1 Yes 2 No Hospital:	Inpatient 2 ER/Outpa		g Home 5 Residence		
n c	ding F h. After funera	io i		Pate of Injury Month, Day, Year) 28b. Tim Injury	ry Work?	28d. Describe how in	jury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. P	lace of Injury - At home, farm, uilding, etc. <i>(Specify)</i>		28f. Location (Street City or Town, Ste	and Number or Rural F ate)	Route Number,
	Hospital 24 hours Funeral stely filled	Medical Ce	(Check only 2 Medical Examiner: On t	o the best of my knowledge, d he basis of examination and/o	eath occurred at the time, date and pi or investigation, in my opinion, death o	ace, and due to the cause ccurred at the time, date a	e(s) and manner as stated	ted. ne cause(s)
	To the within 2	Mec			29c. License number	29d. I	Date signed (Month, Da	ıy, Year)
	1 1		the ma		29c. License number D18726 De, Print) Prince Pus	No	vember s	7, 200 9
	V		30. Name and address of person who completed	cause of death (Item 23a) (Ty	RIOI PA DI	De OLL	L. 412	0832
	Sta	_	31. Date filed (Month, Day, Year)	2. Registrar's Signature	Rad I	p - p - wi	9/0	
DHY	Registr	100	MUATS SONA	Sever B.	Garas .			

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Frederica Coffey November 7,2009 11:08A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens of Columbia Howard Columbia 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F September 13,1931 New York Director 052-26-3481 Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Position Event, item of the 1 □Yes 2 No Director Md. Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20794 USA 8733 Fairhaven Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Specify: White ģ 1 ☐Yes 2X No Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Firm Paralega1 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah L. Wood ပ္ Floyd L. Torrey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8733 Fairhaven Place Jessup, Md. 20794 Lisa Ann Dolan DTR. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-11-2009 Balto. Md. Bayview 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Schimunek Funeral Home Ĭ 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 (2 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Asst. Living 1∐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29b. Signature and the of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6518 Meadrouvro MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

09-08651 Peter John Cave	ende		pe or Print i						egible.			
		1- For State Registrar			tificate c				Reg. No.	200	9 3620	
Physici Medical Exami		Decedent's Name (First, Midd						2. Date of De Month	Day er 7, 2009	Year	3. Time of Death 0213 hrs	
		Peter John Cavend 4a. Facility Name (if not institution	er on, give street and n	umber)		4b. City, Town, or	Location of Death			inty of Death	1	
/		12290 Green Meadov	·			Columbia	T	12 - 2 - 2 -	How			
Funeral Director		5. Social Security Number 171-54-6092	6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days			•	Foreig	thplace (State or gn	
		Usual Residence of Decedent	1_XM 2_F	45	Yı	S.	J	Aug 14	, 1964		Wash DC	
k au &		10a. State 10b. County 10c. City, Town or Location										
Active Maryland 28a-f show a	ip	MD Howa 10e. Street and Number	rd	Co1u	mbia	10f. Zip Code		T	10g. Citizen o	of What Cou	1 Yes 2 No	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director		D.				<i>t</i> .		.09. 020		,	
h with ms 23;		12290 Green Meado 11. Marital Status	12. Was De	cedent Ever in U.		/as Decedent of His Yes, specify Cuban	panic Origin? (Sp			<u>USA</u> Race - Amer White, etc.	ican Indian, Black,	
er deatl	Funeral	1 Never Married 2 XX M	1 Yes	2 X X No				Rican, etc.)			White	
urs afte tural"	d by	3 Widowed 4 Dir 15. Decedent's Education (Spe	vorced If Yes, Give Ye or Dates: ecify only highest gra		16a. Decede	Yes 2 XX No ent's Usual Occupat	ion (Give kind of v		Special Specia	of Business/		
6 172 ho an "na cal Ex	lete	Elementary/Secondary (0-12)		1-4 or 5+)		most of working life.		red)				
215-0036 be filed within 7 ttal Hygiene. *ked other than ent, the Medica	Completed	12 17. Father's Name (First, Middle	2 (ast)		Compu	ıter Program	mer 18.Mother's Name	(First Middle		<u> </u>	Technology	
215 be filed ntal Hy rked of	Be C	John C. Cavender	, 2001)				Diane St	•	, maraon our	iamo,		
5 21 should in Mer is man	٢	19a. Informant's Name/Relations				ng Address (Stree			umber, City or	Town, State	e, Zip Code)	
mand 2 sho lealth and tem 27 is		Diane Cavender 20a. Method of Disposition	Mother			Box 367, Hop		PA 18824 Date	20c. Loca	tion - City or	r Town, State	
MOFe, Pages Lantent of He		1 Burial 2 XXCrematio	_		crematory or o		Nov	10, 2009	Baltim	ore, MI)	
Baltin permit. P Departme Importar injury or	i	4 Donation 5 Other S 21. S ture of Funeral Se vice				Name and Address						
		k. Gregory Fink		148	NI.	426 Crain B	Hwy S., G1	en Burni				
Physician /Medical	ļ	23a. Part I. Enter the diseas, failure. List only one cars	on each line.						irrest, snock, o	or neart	Approximate Interval Between Onset and Death	
xaminer		Immediate Couse (Final disease or condition resulting in death)		a consequence of		iovascula	r diseas	e				
ĺ	<u>اة</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as:	a consequence of	n.							
	Examiner	Cause: Enter Underlying Cause (Disease or injury that initiated	Underlying Cause c									
ecuted and transit		events resulting in death) Last	d.	a consequence of	1):							
be exectician au	sician/Medical	X UNPENDED	AMENDED	23а,27,	permE.	g898 12/	21/09 TT					
Box 68760, death certificate be exthe attending physician of for use as the burial	J/Me	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes,	outcome of pregi	nancy	etal death 3	Ectopic pregna		23d. Da Mor	ate of deliver	ry Day Year	
ox 68 th certi	sicia	past 12 months?	4 Preg	nant at time of de	-th -	Other (Specify)	cotopic progni				Day Tour	
b. Bc the dea by the a	Phys	Part II. Other significant condi	9 Ulki		esulting in the	underlying cause g	riven in Part I	23e. Did	tobacco use	contribute to	the cause of death?	
b, P.O. ires that the signed by signed by I be detach	٥				Journal of the tree	and any major s	,				bably 4 Unknown	
cords, law requir has been s	Completed							24a. Wa	s an 2		utopsy findings available completion of cause of	
Reco The lav	mo							per	formed?	death? 1 ✓ Y		
Ital Recional Recional Recipiest Continued Recipiest Processing Recipiest Re	Bec	25. Was case referred to medica examiner?	Hospital:				of Death (Check					
7 of Vil ling Physic After this	욘	1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatier 28b. Time of		Other: Nursir	g Home 5 28d. Describ	Residence e how injury o		er: Scene	
ion c tending eath. tor: Af the fun	ţį	1 X Natural 5 Pen	ding	h, Day,Yeár)			Yes 2 No					
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Cou	id not be	ce of Injury - At ho	ome, farm, str	eet, factory, office b	ouilding, etc.	28f. Location or Town,		lumber or R	ural Route Number, City	
E 8 E		4 Homicide	rmined (Specify,		- 4 "							
To the Hos within 24 h To the Fun	Medical	(Check only	hysician: To the be miner: On the basis	of examination a								
F.W. C	Me	29b. Signature and tille of certific	and manner:	oldleu.		29c. Licens			29d. Date	signed (Mo	onth, Day, Year)	
		- 1//				O.C.	M.E.		Novem	ber 7, 20	009	
OCM		30. Name and address of person Mary G. Ripple MD.	who completed cau Deputy Chief	·		11 Penn Street	, Baltimore. N	1D 21201				
St	ate	31. Date filed (Month, Day, Year)		egistrar's Signat		4.1						
Regist	rar	MAY 121			V 157	W WORLD						

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Medi Exami

Division of Vital Records, P.O. Box 68760,

To the Funeral Director: After this certificate has been signed by the attending physician and

ian	1. Deced	gistrar dent's Name (First, Middle	le, Last)				ertificate d		2. Date o			Year	3. Time of Death
cal		n T. Coady					,		Novem		ay 2		1:27 P
ner		ity Name (If not institution			nber)		1	n, or Location o	f Death			y of Death	1 1
		Marley Sta			7	(4 t- t- 4td-	Glen I		A Hrs. Lo. Data		nne	Arund	
	219	-28-3703	6. Sex 1 ∑ M	2□ F	7. Age (In yrs. 1	Yrs.	Months Da			, Day, Yea	r) .933		place (State or Fore ntry) 1land
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. I											10d. Inside City Lin	
to	Maryland Anne Arundel Glen Burnie										1 □ Yes 2 🛚		
Director	10e. Stre	eet and Number					10f. Zip Cod	е		10g. (Citizen of	What Cour	ntry?
a D		Marley Star	tion :	Rd.			21060)		Uni	ted	State	es
To Be Completed by Funeral Director	11. Marit	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 11. Was Decedent Armed Forces? 12. Was Decedent Armed Forces? 13. Was Decedent Armed Forces?			ces? 2 ∑ No e	S. 13	B. Was Decedent of If Yes, specify C	uban, Mexican	gin? (Specify Yes o , Puerto Rican, etc.	pecify Yes or No- Decify Yes or No- Decify Yes or No- Decify: White, e Specify: Whit			etc.
Completed		15. Deceden (Specify only highe	nt's Education	on		(Gi	cedent's Usual Oc le kind of work do . DO NOT use re	ne during most	of working	16b.		Business/In	
l di	Eleme	entary/Secondary (0-12)		College (1-	4or 5+)		trician	ii cu)		M	anufa	actur	ina
Ö		er's Name (First, Middle,	Last)			niec.	CIICIAII_	18. Mother	r's Name (First, Mic				
To Be		ncis Coady						Rut	h Catheri	ine H	artl:	ine	
-		ormant's Name/Relations	ship <i>(Type.</i>	Print)	-	19b. Ma	iling Address (Str		r or Rural Route N				o Code)
		ron Coady /				1	Marley	_				e, MD	
13 0	1	thod of Disposition	Daug	IICCI	20b. P				Date			- City or To	
	4 🗆	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State Nov. 14, 20c. Location - City or Town, State Nov. 1											
	21. Sign	atule of Fineral Service	Censee	m	0136	J 4	irkley-k 21 Crain	uđďick" Hwy.,	Funeral S.E., G1	Home, en Bu	P.A rnie	, MD	21061
edical Examiner													
n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date o									ate of deliv	ery		
Physician/M	in tl 1 [9 [in the past 12 months? 1									Ionth	Day Year	
þ	, , , , , , , , ,	ther significant condition	ons contrib	uting to de	ath but not resu	ulting in the	underlying cause	given in Part I.					he cause of death bably 4 🗀 Unkn
b	-								{	Was an autopsy performed?	.		opsy findings available on pletion of cause
ompleted	25. Was	1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only)									10	10100	2,0110
3e Completed	- exam	niner? Yes 2 <mark>∰</mark> No	Hosp	oital: 1 □ II	npatient 2 🗆	ER/Outpat	ent 3 DCA	Other: 4 Nu	rsing Home 5 🔣 I	Residence	6 🗆 01	ther (Speci	fy)
æ				28a. Date o	of Injury n, Day, Year)	28b. Time Injury	' V	njury at Vork? □Yes 2□N	28d. Descri	ribe how in	jury occu	rred	
To Be	1 \(\text{\tinx{\text{\ti}\text{\texi{\text{\texi}\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\texi{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\t	Natural 5 ☐ Pendin Accident investi	ng gation	(mona	-	/ - At home, farm, street, factory, office 28f. Location (Stre					eet and Number or Rural Route Number, State)		
To Be	1 \(\text{\tinx{\text{\ti}\text{\texi{\text{\texi}\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texit{\tet{\text{\text{\text{\text{\text{\texi}\tint{\text{\texi}\ti	Natural 5 ☐ Pendin	ng gation not be	28e. Place	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, s	street, factory, offic	ce	28f, Locati City of	on (Street r Town, Sta	and Num ite)	ber or Run	al Route Number,
edical Certification: To Be	1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Natural 5 Pendin investig Suicide Homicide 6 Could indeterm retifier 1 Certifyir 2 Medical	ng gation not be nined 2	28e. Place buildir an: To the	g, etc. (Specify best of my kno	y) wledge, de	ath occurred at th	e time, date an	28f. Locating City on the desired at the terms of the desired at the desired a	the cause	ate) e(s) and r	nanner as	stated.
To Be	1 ☐ \\ 27. Manr 1 ※ N 2 ☐ A 3 ☐ S 4 ☐ B	Natural 5 Pendin investig Suicide Homicide 6 Could indeterm retifier 1 Certifyir 2 Medical	ng gation not be nined 2	28e. Place buildir an: To the	g, etc. (Specify best of my kno	y) wledge, de	ath occurred at th investigation, in n	e time, date an ny opinion, deat ense number	d place, and due to	the cause ime, date a	e(s) and read place Date sign	nanner as , and due t ed (Month,	stated.
edical Certification: To Be	27. Manr 1 2 1 4 1 1 2 1 4 1 1 1 2 1 1 4 1 1 1 1	Natural Accident Suicide Homicide 1 Certifyir eck only e) Pendin investig 6 Could determ determ 1 Certifyir 2 Medical	ng gation not be nined 2 ng Physici. Examiner:	28e. Place buildir	best of my kno usis of examina er stated.	wledge, de tion and/or	ath occurred at the investigation, in not be a second or	e time, date an ny opinion, deal ense number 551	d place, and due to	o the cause ime, date a	e(s) and r and place Date sign	manner as , and due t ed (Month, er 11	stated. to the cause(s) Day, Year) 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ VIN ORLEY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death County of Death heran Nursina 1MOCE 8. Date of Birth (Month, Day, Funeral 9. Birthplace (State or Foreign Country) Director Usual Residence of Decedent or 28a-f shov 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shoot traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funera! 2120 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BOCK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of hemist turs. Be 17. Father's Name (First, Middle, Last ပ aughman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, and 2 s Health a Marlen-e 7209 St. Lukes Wife Department of Healt Important: If item 2 any injury or other t injury or other Method of Disposition 20b. Place of Disposition (Name of ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other Garrison Forest Owinas Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee C. Greene funeral sins Randallstown MD21133 23a. Part 1. Enter the disease, or complications that caused the death shock, or he are ailure. List only one cause on each line. Do not enter the mode of dying, such as ardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARKINSONS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or sele consequence of that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 the attending phones that IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific, completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) suelle MJ) Name and address of person who completed cause of death (Item 23a) (Type, Print) BALD 2120 Ms AKHAMI, 2835 Sm 1774 31. Date filed (Month, Day, Year) State Registrar

09-08423 Ivana Creighton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 36208

			1- For State Registrar		, maryic			cate of	Death					eg. No.	20		3020
edio	Physici al Exami	an/	1. Decedent's Name (First, Middle,Last) IVANA NICHOLE CREIGHTON 2. Date of Death Month Day Year October 30, 2009								16	ne of Death 609 hrs					
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1428 Stonewood Road 4c. County of D Baltimore														
	Funeral Director		5. Social Security Number 218-04-8314	ecurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Da Months Days Hours Min. 0.5							8. Date of Bi		70 Fo	Birthplace reign Ma Country).	State or ryland Marylan		
	r death with the Maryland or items 23a or 28a-f show any must be notified at once.	al Director	MD N	N/A				BALTIMORE 10f. Zip Code 21239					10g. Citizen of W U . S Specify Yes or No- 14. Raci			1 A	Inside City Limits Yes 2 No
e.	and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho tranmatic event, the Medical Examiner must be notified at once.	leted by Funeral	Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5)				No 1 Yes 2 No specify: Specify: Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of E					LACK ess/Industr					
24245 0025	filed within It Hygiene.	e Completed	12th Grad 17. Father's Name (First, M Edward Le	ddle, Last)	urlir	at on		Ac	coun	18		Name (First, Middle,		MT. urname) ghto:		
MD 242	2 should be and Menta 27 is marke	ToB	19a. Informant's Name/Rela	tionship (Ty	pe, Print)								ural Route Nu	ltim	ore,	MD	21239
A Cacaitica	permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examinez.		20a. Method of Disposition 1 Burial 2 Crer 4 Donation 5 Ott 21. Signature of Funeral Section 1.	er Specify: rvice Licens	see	rom State	Loud	OT. I	er place) ark ame and A	Cem	of Facility	11/1 own	Jr.	Ba Fune	ral	ore,1	Maryland
	Physician /Medical caminer		23a. Part I. Enter the disea failure. List only one of Immediate Cause (Final dis or condition resulting in de	ause on ea ease a	ications that on the line. Cardia Due to (or as	c arr	hyth		ne mode of	dying, s	uch as ca	rdiac of	respiratory a	rrest, Shoci	k, of hear	Ap Be	mate Interval etween Onset and Death
	recuted n and - transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying C (Disease or injury that initial events resulting in death)	b ause ted c	Electr Due to (or as Hypert Due to (or as	olyte a conseque ensio	e dis									+	
00700	ath certificate be es attending physiciar or use as the burial	Physician/Medical	XJNPENDED IF FEMALE: 23b. Was decedent pregnal past 12 months? 1 Yes 2 No 9	Х	1 Live	, outcome o	of pregnar	2 Fe	27 pe g897 tal death	3	2709 Ectopic			23d.	Date of de	elivery Day	Year
	es that the igned by the oe detached	Completed by Phy	Part II. Other significant of	onditions	contributing	to death bu	ut not resu	ulting in the u	inderlying	cause gi	ven in Par	rt I.	1 Y 24a. Wa aut per	es 2 🗸	No 3	Probably ere autops	ause of death? 4 Unknown y findings available eletion of cause of
	rian: The certificate ector, page	Be Co	25. Was case referred to n						2	_		(Check o	only one)				
727.3	Physici Prysici er this c eral dire	₽	examiner? 1 ✓ Yes 2 N 27. Manner of Death		lospital: 1	Inpatient e of Injury		R/Outpatient 8b. Time of I			Other ₄		g Home 5 28d. Describ		ry occurred		ene
	_ ≛ . ~ ≥	Certification:	1X Natural 5 2 Accident	Pending Investigation	on 28e Pis	th, Day,Year)		e, farm, stre	et, factory,		es 2				nd Number	or Rural F	Route Number, City
Č	LIVISION Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certif	3 Suicide 6 4 Homicide 29a. Certifier	Could not determine	Specifi	()							or Town		d		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medica	ing Physici I Examiner	an: To the basis	s of examin	nowledge, nation and	, death occui /or investiga	tion, in my	opinion,	death oc	curred a	t the time, da	ite and plac	ce, and du	e to the ca	
0	F 3 F 3	Me	29b. Signature and title of	certifier	6	Tel.	6	9081	290	O.C.N	number .E.				ober 31,		Day, Year)
			30. Name and address of p		completed ca				Penn Str	reet, B	altimore	e, MD	21201				
	Regi		31. Date filed (Month, Day)	Year 20		Registrar's	Signature		Red								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 1250 PM **Physician** october Shandra Carr 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year If Under 1 Year | If Unde 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 3 1 M 2 X F 50 Oct 28, 2009 Maryland infan t Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show aţ 1 Yes 2 No notified Director Harford MD Abingdon 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f Zin-Code ö must be 21009 USA 714 Kirk Caldy Way 23a Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or item iny or other traumatic event, the Medical Examiner. 1 Yes 2) If Yes, Give Year or Dates 1 X Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 Yes 2X No black Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shanda Carr Jason Carr 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 600 Wolfe Street Baltimore, MD 212287 The Johns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 📉 Other (Specify) in state re of Funeral Serv 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immedia Cause (Final disease o condition Waller Dund Malformation **Physician** /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sunsequence of, Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Month in the past 12 months? Veal ò Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 M No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\bigcap\) No ate has page 2 1 🗌 Yes 2 🗌 No 1 X Yes certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 💢 No 1 🕱 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No death. s after death.

I Director: A d in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hin 24 hours af the Funeral DI mpletely filled in 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I complex 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10128109 000-296 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Ibrahi 11, Ne 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of M	Cer	tificate of De		rental Hyg	leg. No. 2009	36210
	Physicia		Decedent's Name (First, Middle,	Last) Helen	Louise	Clay		2. Date of Deat		3. Time of Death 9:25 A M
	Medic Examin		4a. Facility Name (if not institution,	-	1 0	4b. City, Town, or L		Novemb	4c. County of Dea	th
	Funeral		Ellicott City 5. Social Security Number		nab Ctr. e (In yrs. last birthday)		tt City If Under 24 Hrs.	8. Date of Birth	Howard (thplace (State or Foreign
	Director		214-24-2703 Usual Residence of Decedent		92 Yrs.		Hours Min.	(Month, Day, June 2	Year) Co	aryland
	/land f show ed at	tor	10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits
	e Mar r 28a- notifie	Director	Maryland How	ard		Elli 10f. Zip Code	cott Cit			1 ☐ Yes 2 ☒ No
	vith th 23a o st be	eral l	3000 North R	idge Road			21043		10g. Citizen of What Co United S1	· ·
	items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13. V	Vas Decedent of Hisp f Yes, specify Cuban,		cify Yes or No- Rican, etc.)	14. Race - Ame	erican Indian,
920	s after or ral", or Examir	ed by	1 ☐ Never Married 2 ☐ Marri 3 🔀 Widowed 4 ☐ Divorced	ed 1 Yes 2 1 If Yes, Give Year or Dates.	No	Yes 2x No		niodin, otoly	Black, Whit Specify:	White
5-0	2 hour "natu	plete	15. Decedent (Specify only highes		16a. Deced	lent's Usual Occupati kind of work done dui	ion ring most of worki	na I	16b. Kind of Business	
21215-0036	ithin 7. iene. r than	Completed	Elementary/Seconday (0-12) 12 Years	College (1-4 or 5	ife. Di	ONOT use retired) ecretary			Paint Cor	nnany
pd 2	filed wall Hygi	æ	17. Father's Name (First, Middle, La	ist)			18. Mother's Name	e (First, Middle, N		прапу
Зa	Ild be Menta narked	욘	Albert Eybs		1.			na P. B		
, Maryland	and 2 shou Health and tem 27 is n		19a. Informant's Name/Relationshi		ghter) _{19b. Mailin} 3542	ng Address <i>(Street an</i> S plit Ra	id Number or Rura il Lane	Route Number, Ellicot	City or Town, State, Zitt City, M	p Code) D 21042
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampirity or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 4 ☐ Donation /5 ☐ Other (Sp.			sition (Name of natory or other place) Iem • Gdns •) [2/2009	20c. Location - City or Bel Air,	
Balti	permit. F Departm Importa any inju		21. Signature divuneral Service Li		Dů	Name and Address	of Facility uneral H	ome of I	Oundalk, In	nc.
			23a. art . Enter the disease, or o shock, or heart failure. List or	complications that caused	the doth. Do not ente	922 Wise ar the mode of dying,				Approximate Interval Between
8	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_a Alkeros	clerotic Co	ircliovasc	ular	Dixea	OL_	Onset and Death
-	Examiner	Ļ	Sequentially list conditions.	b.	a consequence of):					
	uted d ansit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a	a consequence oij.					
_	cate be executed physician and the burial-transit	Aedical Examiner	resulting in death) Last	Due to (or as	a consequence of):					
3760	ificate I ig phys as the	/edi		d						
Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral after death. Funeral pirector: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3 E	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
s, P.O.	res that th signed by d be detac	Completed by Ph	Part II. Other significant condition	ns contributing to death b	ut not resulting in the u	nderlying cause giver	n in Part I.		pacco use contribute to	the cause of death?
ord	w require s been si should	olete						24a. Was a	n 24b. Were au	topsy findings available
Rec	The law cate has page 2 s	Com						autops perform 1 \(\sum \) Yes	med? death?	completion of cause of
ta	s ician : The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		26. Plac	ce of Death (Check			
Division of Vital Records,	ding Phys h. After this funeral dii	ate: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of inju	ent 2 ER/Outpatien ry 28b. Time of injury	t 3 □ DOA 28c. Injury a work?	4 Nursing Ho		ence 6 Other (Spec w injury occurred	cify)
/isior	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Certificate:	2 ☐ Accident Investigs 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be 280 Place of Inju	ury - At home, farm, stre		es 2 No	28f. Location (St.	reet and Number or Ru	ral Route Number,
ă	spital o nours af neral Di filled in		29a. Certifier 1 Certifying	Physician: To the best of		occured at the time, d	date and place, and			ated.
	the Ho	Medical	(Check 2 Medical Ex	kaminer: On the basis of e Nurse Practioner: To the	xamination and/or invest	igation, in my opinion, leath occurred at the t	, death occurred at time, date and place	the time, date and e, and due to the	d place, and due to the cause(s) and manner as	cause(s) and manner stated. stated.
	o o vit		Signature and title or certifier	Sample		29c. License n	o 641		9d. Date signed (Monti	
			30. Name and address of person w Ramest, Sabapa	ho completed cause of d	eath (Item 23a) (Type, P BGCL LIVE O	rint) VCK Road	Balhn		May land	2/22/
	Stat Registra		31. Date filed (Month, Par Year)	2 2009 32. Pegistra	er's Signature	ask			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ΡМ Dorothy Conroy 2009 Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Futurecare Chesapeake Anne Arundel Arnold 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 26, 1939 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Mary Land Director 218-36-7768 70 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be one. Funeral 1305 College Parkway 21012 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 X Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Secretary Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Conroy Marv Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Schadel (Sister) 27002 Nature View Street Leesburg. F1a 34748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/03/09 <u> Atlantic Crematory</u> Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final REWAL Enysician/ VOA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown Month Day Year the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown ours after death. eral Director: After this certificate has been signed by t filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTOUSIEN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown BIPOUR DEPRESSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☐ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D46360

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2009 36212 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2, 2009 Peggy T. Cassidy November 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔽 F 464-30-2654 86 Kansas Director July 14, 1923 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6221 Valley Road 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify White ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Timken ဨ Greta Roach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert C. Cassidy, Jr./Son 9501 Seddon Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 7, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licens Million M01173 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, learning to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine The law requires that the death certificate be executed Arteriosclerosis and as the burial-trar Due to (or as a consequence of): P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown certificate has been signed by irector, page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🛛 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 💢 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number aulmo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue, Suite 515, Chevy Chase, MD Eva Hausnerova, M.D. 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MOV 1 2 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 9, Chandler 11:28 P^M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11402 Newport Mill Rd. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 □ F 215-54-9719 89 Director Jan. 3, 1920 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shorewort, the Medical Examinar must be notified at Director MDMontgomery Silver Spring 1 ☐ Yes 2\ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11402 Newport Mill Rd. 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2 X No Specify: White Specify: ð 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any Injury or other traumatic event, it is I walf. once. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Special Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be M^CGuire Williams Travis Laura ပ္ 19a. Informant's Name/Relationship (Type. Print)

Joseph B. Chandler / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8706 Nightengale Dr., Lanham, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/11/09 Beltsville, MD 21. Signature of Funeral Sarvice Licens Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Ent. Ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Vacual ar Dementia Gist Ave., Silver Spring, MD 20910 Approximate Interval Between Onset and Death years Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent premant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 🔲 Ectopic pregnancy Month 5 Other (specify) ed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐ No Vital 1 ∐Yes 2 **(N**) To the Hospital or Attending Physician: : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) ð 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier BARRY RESENBAUM 3720 FAIRAGUT 30. Name and address of person who completed cause State 31. Date filed (Month. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2:30 PM November 7, Bobby Lee Cheek 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital of Cecil County Cecil Elkton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, Year) **Funeral** 12M 2□ F Months Days Hours Min. Jan 14, Director 216-38-2618 1941 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 □ Yes 2 No Funeral Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examinat must be 1. 100 Laural Dr. 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ € 0 If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Harford Mall Maintanence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Connie Lee Cheek Larua A. Sexton ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Cheek /Daughter 214 Marshall Dr. Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important: If It any Injury or co 10 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Nov Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute hypoxio repretory
Due to (or as a presequence of): 48 40513 disease or condition resulting in death) /Medical Examiner 13stituturi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of) Chronce resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Allhermeri 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peripheral Usscalar diceso 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Dibetes Type 1 ☐ Yes 2 ☐ No 1 □Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

P.O. Box 68760. Division of Vital The law requires that the death certificate be executed

and burial-trai

attending physician

signed by the a

has been

After this certificate

or Attending Physiclan:

death.

To the Hospital within 24 hours a To the Funeral C

s after death.

page 2

filled in by the funeral

completely

Medical

2 Accident

4 ☐ Homicide

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

6 ☐ Could not be

afaasting

determined

Pino

the use as

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10055190

Hospital 106 Bow St Elleton UND

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Duron

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2009

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 6

Physician/

Medical

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

28a-f shov

23a or

"natural", or items 72 hours after death

other traumatic event, the Medical Examiner must be notified at

Physician/ Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed

any injury

attending physician and for use as the burial-tran ed by the a detached i sate has been signed page 2 should be det thin 24 hours after death.

the Funeral Director: After maniple of the further of

Division of Vital Records, P.O. Box 68760

Physician/Medical

ρ

Completed

Certificate:

Medical

29b. Signature and At

SAYED 31. Date filed (Month, Day, Year)

of certifier

NOV 1 2 2009

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25 Be မ 27.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?				
DIABETES	MELLITUS			1 🗆 Yes	2 □ No 3 □ Probably 4 ☑ Unknown				
	AL VASCULA		ASE.	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No				
25. Was case referred to medical			26. Place of Death (Che	eck only one)					
examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3 🗆	DOA Other: 4 \(\sum \) Nursing I	Home 5 A Residence	6 ☐ Other (Specify)				
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	(Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine				8f. Location (Street and Number or Rural Route Number, City or Town, State)					
	hysician: To the best of my know				and manner as stated.				

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

5601 LOCH RANEN BLUD BALTIMORE

29c. License number

Kes 000

29d. Date signed (Month, Day, Year)

21239

NOVEMBER

MD.

2009

State Registrar

within 2

To the I

comple

MD

Registrar's Signature

30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 36216 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 06:25AM COGAN SEL MA November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Sinai Hosnitel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10 | 02 | 19 14 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 XF 95 PA 056-05-7598 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County ral", or items 23a or 28a-f show Examinar must be notified at MD N/A BALTIMORE 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 6111 BILTMORF AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: WHITE þ 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL KAIZEN TDA **HOFFMAN** ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 BILTMORE AVENUE, BALTIMORE, MD 21215 CHAVA ROSEN/DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHEARÍTH ISRAEL CÉM. 11/09/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS.. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTROINTESTINAL **Physician** INK /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Director for the in consequence offi trans, leading to transection cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 MELLITUS BIABETES 1 Yes 2 No 3 Probably 4 Onknown Completed FAILURE RENAL 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 DNO 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier RES-000 ALOMAITYTE JURGA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospitel of Baltimore JUR6A ASOMAL MYTE Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Bryant Langley Del Vecchio Betty November 2009 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 29983 Shoreview Drive St. Mary's Mechanicsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🕱 F 219-28-0107 76 Director 12/12/1932 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: file TS Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, he "sected Examines must be notified at 1 □Yes 2 TVNo Director MD Mechanicsville St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 29983 Shoreview Drive U.S.A. 20659 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White ģ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 12 should be filed w h and Mental Hygier 7 Is marked other th 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Odel Bryant Mittie Beaulah Pinion ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11581 Overleigh Drive, Woodbridge, VA 22192 Diana Rock/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 11/12/2009 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licen is 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dee to for as a consequence off executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Ye ar Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No 1 □Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division the Hospital or Attending 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) D LINE CENTER WALDONF, MG ZOGOZ 1201 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar		State of Ma	iryland		artment of F tificate of				jiene <u>/</u> leg. No.	.009	36210
	Physici	20	Decedent's Name (First								2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		Joseph Ho	ward 1	Dutton, Sr	•					Novembe	r 6,	2009	6:15 A M
	Examir	er	4a. Facility Name (If not in	-				4b. City, Town, o	or Locatio	n of Death		1	County of Death	
			Hospice of		peake			Linthic					nne Aru	
	Funeral		5. Social Security Number	4.5	x 7. Age	(In yrs. las		If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Birth (Month, Day	(, Year)	9. Birth	place (State or Foreign intry)
۱	Director		212-52-2850		X) W Z L I	60_	Yrs.		1		6/4/19	49	Ma	ryland
	and *		Usual Residence of Dece 10a, State 10b.	. County		10c. City.	Town or Lo	cation						10d. Inside City Limits
	sho	ក		nne Arı	undo l		oklyn							1 ☐ Yes 2 ☒ No
	288-	ect	10e. Street and Number	THE AL	under	DIC	OKTYL	10f. Zip Code	_			10a Citiza	en of What Cou	ntry?
	with a	ā	916 Victor	v Aveni	10			21225	-305	1			.S.A.	,
	leath	era	11. Marital Status	7 11 011	12. Was Decedent B	ever in U.S.	13. \	. 1			city Yes or No-		4. Race - Ameri	can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or iteme 23s or 28s-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 3 ☐ Widowed 4 🔀		Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub l □ Yes 2☑ No			Rican, etc.)		Black, White Specify: Wh	
Ö	2 ho	ted		Decedent's Ed			16a. Deced	dent's Usual Occup	pation	oat of worki	30	16b. Kin	d of Business/Ir	ndustry
215	thin 7	pie	Elementary/Secondary	hy highest grad (0-12)	College (1-4or 5	+)	life. L	kind of work done DO NOT use retire	duning m d)	OSL OF WORK	ng .			
7	d gien wi	Ö	8				Body	Repair	Tech	nicia	ו	Auto	omotive	
b	ai Hy ai Hy aoth	Be (17. Father's Name (First,						18. Mo	ther's Name	(First, Middle,	Maiden S	Sumame)	
<u>yla</u>	Ment Ment arke	2	Harry Wi	lliam	Dutton, S	r.			Del	ores	,		Z	immerman
Maryland	and and in m		19a. Informant's Name/F	Relationship (7	ype, Print)	- 1	19b. Mailir	ng Address (Street	and Nun	nber or Rura	l Route Numbe	r, City or	Town, State, Zi	p Code)
3,	and ealth m 27		Joseph Dutt		./ Son	1		Crestha	ven					
ore	of H of H H ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre		Removal from State	20b. Plai	ce of Dispo netery, cren	sition (Name of natory or other pla	ice)	C	ate	20c. Loc	ation - City or T	own, State
Ë	Pag ment ant: uny d		4 ☑ Donation 5 🗆			Anat		fts Regist	•				ver, Ma	
Baltimore,	Depart Import eny inj		21. Signature of Funeral	Service Licen	•			. Name and Addre 522 Conn			•		•	•
			23a. Part1. Enter the dis shock, or heart failu	ease, or comp	lications that caused	the death.	Do not ent	er the mode of dyi	ng, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
1	Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death)	(a. Lune Due to (or as	7 C	ance							Onset and Death
	7 =	ner	Sequentially list condition if any, leading to immedi- cause. Enter Underlying Cause (Disease or injury that initiated events	ato	Due to (or as :	i conseque	nee of):							
	cutec	Examiner	Cause (Disease or injury that initiated events		c									
o,	e exe ien a urial-	Ä	resulting in death) Last		Due to (or as a	a conseque	nce of):							
68760,	licate be executed physicien and s the burial-transit	dical			d									
	artifica ing pl		IF FEMALE:											
P.O. Box	Physician: The law requires that the death certifi this certificete has been signed by the ettending ratidirector, page 2 should be detached for use as	Physician/M	23b. Was decedent preg in the past 12 mont 1 Tyes 2 No 9 Unknown	manit	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal d	eath 3	Ectopic pregnanc Other (specify) _	y			23	3d. Date of deliving Month	rery Day Year
	quires that the de n signed by the e uld be detached f	Ď	Part II. Other significant	conditions co	ontributing to death bu	ıt not result	ing in the u	nderlying cause gn	ven in Pa	rt I.	23e. Did to			the cause of death?
Division of Vital Records,	The law requir ste has been si sage 2 should l	Completed				·					24a. Was autop		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
ita	stan: ortific ctor.	Be C	25. Was case referred to examiner?	medical					26. Pla	ace of Death	(Check only o	ne)		
Ž	hyeic his ce idire	2	1 ☐ Yes 2 No		Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatien	t 3□ DOA Ott	17	ursing Hor	ne 5□ Resid	lence 6	E Other (Spec	IN HOSPIE
20	e fe		27. Manner of Death Natural 5	Pending	28a. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury	28c. Inju Wo	ry at		28d. Describe h	ow injury	occurred	,
sio	Attending or death. ector: After by the fune	cati	2 Accident	investigation Could not be					Yes 2	_				
Ë	or Atl	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	28e. Place of Inju		e, farm, str	eet, factory, office		1	28f. Location (S City or Tow		Number or Rui	al Route Number,
Ω	urs a urs a aral D													
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medicai	29a. Certifier (Check only one)	Medical Exam	rsician: To the best of inar: On the basis of and manner sta	examinatio	edge, death n and/or in	n occurred at the tr vestigation, in my o	me, date opinion, d	and place, a leath occurr	and due to the o ed at the time, o	date and	and manner as place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of	of certifier	11.			29c. Licens				1.	signed (Month	Day, Year)
			the	11/10	MELL	_		20	145	32		100	v e mo	0,2004
			30. Name and address of Sool Sou		completed cause of de	eath (Item 2	3a) (Type.)	Print) C IMOVE,	Ma	d fi	Van E	Ea ho	5 MF	
	Sta	te	31. Date filed (Month, Da		32. Registra	ır's Signatu	re	.00	-	-	-	-	=	
	Registr	ar	NOV	1 1 2 20	119 Pen	N B	. 206							

State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** AM 330 2009 Deenon Diehl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Augsburg Lutheran Home Baltimore Gwynn Oak 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☑ M 2 □ F Director 30, 1917 Pennsvlvania Nov. Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, I'm Madical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 6825 Campfield Rd. 21207 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Š Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Electric 12 Department of Health and Mental Hygis Important: If Item 27 Is marked other is any Injury or other traumatic event, Ill once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Florence Lease ပ္ Ervin Preston Diehl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Diehl / Wife 6825 Campfield Rd. Gwynn Oak, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Freysville Union Cem. Nov. 10,2009 Freysville, Pennsylvania of Funeral ervice Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 21061 421 Crain Hwy. SE Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying vause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The certificate performe 1 ☐Yes 2 ☐No 1 □Yes 2 No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 □Yes 2 □No 2 Accident investigation thours after death uneral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a Hospital 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R144682 11-6-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V 25 Main Street Sto MD 200 eisterstown, 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Maryla	and / Depa <i>Ce</i>	artment of F rtificate of I	lealth and Death	Mental Hygie	ene2009	36220
	Physici	an	1. Decedent's Name (First, Middle, Last)	, _ ,				2. Date of Death	Day Year	3. Time of Death
	/Medic	cal	Helen R. Durs			41- 07- T	- L - astism of Doo	November	er 2,200°	
	Examir Funeral	ner	4a. Facility Name (If not institution, give s WMHS - Me Mo 5. Social Security Number 6. Sec.	rial CAM	OUS rs. last birthday)	If Under 1 Year Months Days	Location of Dea	and 8. Date of Birth	1 . 1	th CAN State of Foreign bunky)
	Director		Usual Residence of Decedent	M 2 X F 8	7 Yrs.	monaro Bayo	T TOUTO	Apr 19,	1922 Mar	y1and
	yland now		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Ba-fs	ctor	MD Garrett		Gran	tsville				1 □ Yes 2x No
	ith th	Dire	10e. Street and Number	201		10f. Zip Code		10g	g. Citizen of What Co	ountry?
	sath v	eral	21 Pa Avenue Box 2	234 2. Was Decedent Ever in	.U.C. 112	21536		Chooify Voc or No	USA 14. Race - Ame	orioon Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the fledged Fyniring must be rudflied at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ሺ No	an, Mexican, Puer Specify:	to Rican, etc.)	Black, White	
2-0	72 hor natura	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	eation	nrkina 16	6b. Kind of Business/	/Industry
121	vithin sne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	d)	,,,,,,,,		
	filed v Hygie other i		12 17. Father's Name (First, Middle, Last)	0	ho	ousewife	18. Mother's Na	me (First, Middle, Ma	own home	
<u>lan</u>	Aental Aental rked c	To Be	Joseph Broderick				Ethe1	Robeson	,	
Maryland	2 shou and h is ma auma		19a. Informant's Name/Relationship (Typ		1 1	•		Pural Route Number, C		. ,
	l and Health		Wayne H. Durst/sp					4 Grantsv		
Baltimore,	. Pages I tment of It tant: If ite jury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)	emoval from State		osition (Name of matory or other place			oc. Location - City or	
Ball	permit Depar Impor any in		21. Signature Fineral Service icense	ade, lirect		L Name and Addre Anat altimore,		d 655 W. I	3altimore	Street
E	Discord discord		26a. Part 1. Enter the disease, or complications of the shock, or heart failure. List only on immediate chuse (Final	e cause on each line.		11.	ng, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
- 1	Physician /Medical		disease or coultion resulting in death)	Due to (or as a cons		mbe(152	<u> </u>			2day)
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	outed id ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	(1.45 d 00)	4 0,000					
ó,	icate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a cons	equence of):					
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O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Sc. If yes, outcome of preg 1 Live birth 2 For 4 Pregnant at time of 9 Unknown	etal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
ď.	s that t ned by e detac	by Ph	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
of Vital Records,	w requires been sign should be							1 □ Yes	2 □ No 3 □ P	robably 4 Unknown
ecc	elawre hasbe e2sho	Completed						24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
<u>~</u>	: The cate had page	Com						performe	ed? death?	2 No
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		oth-	or:	ath (Check only one)		
	Phys rrthis rral dii	7. 10	1 Yes 2 No □	28a. Date of Injury	☐ ER/Outpatier 28b. Time o	IL 3 LI DOM	4 Li Nursing	Home 5 Residence 28d. Describe how		ecify)
ion	Attending F r death. ector: After by the funera	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year,) Injury	Worl	ć? Yes 2 □ No	255, 2555, 25	injury occurred	
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	Hospit 4 hour Funera tely fille	Medical C	29a. Certifier (Check only one) Certifying Phys 2 Medical Examir	ician: To the best of my ker: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the til vestigation, in my o	me, date and place pinion, death occ	ce, and due to the cau curred at the time, date	ise(s) and manner a e and place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Me	30. Name and address of person who conduction. 31. Date filed (Month, Day, Mar)	~5		29c. Licens	e number	290	Nov 3, 2	th, Day, Year)
			30. Name and address of person who con	npleted cause of death (I	tem 23a) (Type,	Print)	1 .	. //	, i	, 21502
			DUNIL Gupta,	mo, 625	Kenti	Hue, Su	ute 10	1, Cumk	Der /ANG	1, md
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	natur	D		*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 2009 36221

David W Demiski		1- For State Registrar	tate or Marylan	-	artment o rtificate o		nd ivienta	• •	Reg. No.	03 3022				
Physicia Vedical Examir	n/	Decedent's Name (First, Midd	David	 	2. Date of Dea Month Novembe	ath	3. Time of Death 2025 hrs	_						
		4a. Facility Name (if not institution Harbor Hospital Cent	-	per)	4b. City, Town, o	or Location of D		4c. County of						
Funeral		5. Social Security Number		Age (In yrs.	ast birthday)	Baltimore If Under 1 Ye	ear If Under 2	4Hrs. 8. Date of B	irth(MM/DD/YYYY)	N/A g. Birthplace (State or				
Director		220 94 4406	1 X M 2 F	45	Yrs	Months Da	Hours Hours	Min. 11/0	1/1964	Foreign Country)Maryland	1			
, any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	tion				10d. Inside City Limit				
Aaryland 28a-f show Lat once.	tor	Maryland 10e. Street and Number	N/A		Baltimo	ore 10f. Zip Code			10g. Citizen of Wha	1 X Yes 2 N	0			
th the Maryland 23a or 28a-f sho notified at once	Director	2517 Southder	ne Avenue				230			S.A.				
within 72 hours after death with the Maryland giene. The than "natural", or items 23a or 28a-f she Mediral Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X M	12. Was Deced Armed Forc	es?				? (Specify Yes or No uerto Rican, etc.)	0- 14. Race - White,	- American Indian, Black, , etc.				
s after de ral", or	by F.		Vorced If Yes, Give Year or Dates:	2X No		Yes 2XN			Specify:	White				
5-0036 led within 72 hours after thygiene. other than "natural", the Medical Examiner.	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)				nt's Usual Occup nost of working lif			16b. Kind of Bus	iness/Industry				
-003(d within giene. ther tha	omo	12th 17. Father's Name (First, Middle	e Last)		Tr	uck Dri		lame (First, Middle,	Truck:		_			
be final rrked	a		Frank W	. Demsl	44-14		Е	stelle A.	telle A. Wisniewski					
re, MD 21215-0 I and 2 should be filed w Flealth and Mental Hygie fitem 27 is marked othe	잍	19a. Informant's Name/Relations Ruth Demski /				g Address (Stre Southder		r or Rural Route Nu ue Balt		n, State, Zip Code) aryland 21230				
imore, MD 21 Pages I and 2 should ment of Health and Me tant: If item 27 is ma	ĺ	20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from	State	crematory or of	sition (Name of co ther place) rematory	· ·	Date	1	City or Town, State				
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service					re, Maryland ice, P.A.							
	1	Flent U	imore, M	laryland 21225	_									
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (heroin) intoxication												
Lxaiiiilei		or condition resulting in death)	Due to (or as a co											
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence o	f):						_			
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760, icate be executed physician and the burial - transit	Medical	X UNPENDED	AMENDED	Ba,27,2	28a-f.p	ermE, g8	398 12/	4/09 TT			_			
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed teath. The The trip certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transil - t		IF FEMALE: 23b. Was decedent pregnant in to past 12 months?	he 23c. If yes, out	come of preg	nancy 2 Fe	etal death 3			23d. Date of d Month	delivery Day Year				
Box 687. He death certific y the attending p hed for use as th	Physician/	1 Yes 2 No 9 Un		t at time of de n	ath 5 O	ther (Specify)			1					
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Division of Vital Records, tal or Attending Physician: The law requirers after death. The Director: After this certificate has been sized in by the funeral director, page 2 should be a proper at the funeral director, page 2 should be a proper at the funeral director.	e B													
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Vision or Attent fler death Director: in by the	ertification	2 Accident Inve	estigation 2 2 1 7		Fd 1957 ome, farm, stre	et, factory, office	71 -2		Street and Number	r or Rural Route Number, City	у			
bou hou	ပႃ	4 Homicide dete	ermined (Specify) Physician: To the best of	other		and at the time	data d -l	Ave. Ba	ltimore,	MD	36			
To the los within 24 h To the Fun completely	Medical	one) 2 Medical Exa	aminer: On the basis of e and manner state	examination a										
	Σ	29b. Signature and title of certific	er	/	4		se number		29d. Date signed November 4	d (Month, Day, Year) 1, 2009				
	-	30. Name and address of person who completed cause of death (lem/23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
Sta	ite	Zabiullah Ali, M.D. 31. Date filed (Month, Day Year)	Assistant Medical			in Street, Bal	Itimore, MD	21201						
Registr		. Date filed (Month, Day Year) 32 (Registrar's Signature												

State of Maryland / Department of Health and Mental Hygiene2 36222 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:29 AM 10,2009 november onald /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**XX**M 2 □ F Days Hours March 5, 1936 **Director** 215-38-9007 MD Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at Yes 2 □ No **Funeral Director** MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō 21206 U.S.A 23a 6005 Arizona Avenue items 2 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2√No Specify: White ģ 3 Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education the Medical (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) State Superintendant University Hospital 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental ? John Willard Dell Anna Virginia Wiles ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If item 27 Is any Injury or other train 9706 Conmar Road Balto, MD 21220 Ronda Penner (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XXurial 2 Cremation 3 Removal from State Maryland National 11/14/2009 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home 3631 Falls Road Balto, MD 212 Part 1. Enter the disease, or complisations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed 06 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ this filled in by the funeral 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: (Month, Day Director; After 1 Natural 2 Accident 5 Pending investigation 2 🗌 No 1 Tes after death Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier november 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 20 36223 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death November **Physician** Mary Jane Duncan 8, 2009 11:20 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Asbury Methodist Home Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2**X** 86 June 6, Pennsylvania Director 315-12-8094 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat" any lijury or other traumatic excellent. 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Montgomery Gaithersburg 1 □ Yes 2XXVo **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Russell Ave. *\$*502 20877 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 Tho 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No White If Yes, Give Year or Dates: Specify δ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Treasurer Secretary Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Reynolds Gertrude Jelly ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David O. Duncan / Husband 419 Russell Ave., #502, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 11/10/09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Rapp Funeral and Cremation Services / leru Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final One month **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be execute burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 □Yes 2 No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Pla of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04115 14. Robert De 30. Name and address of person who completed cause of death (Item 23 (Type, Print) 201 Russell & ven IL ROBERT SIRSCHS ALL, MD Conthers bury ML 31. Date filed (Month, Day, Year) NOV 12 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		For State	State of	Maryland	/ Depa	rtment of tificate of	Health a Death	and M	lental Hy	giene Reg. No	2009	362	224		
		Registrar 1. Decedent's Name (First, Middle	le, Last)						2. Date of D	eath		3. Time of D	Death		
Physici		RALPH GORDON	I DANTET						Month NOVEME	Da RER 7	y Year 2, 2009	11:20	7 M		
/Medio Examir		4a. Facility Name (If not institution		ber)	·	4b. City, Town,	or Location of		THO VILLE		. County of Deat		A		
		338 Harlan S	Square			Bel Ai	r			Н	arford				
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. las		If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of B	irth Day, Year)	9. Birt	thplace (State or untry)			
Director		228-52-2039	MEJM 2LIF	67	Yrs.					19, 1	.942	Virg	inia		
pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	ation						10d. Inside City	/ Limits		
f sho	ō											1 XYes	2 □ No		
28a-	Director	Maryland Har	rford	Be.	l Air	10f. Zip Code				10g. Cit	tizen of What Co	untry?			
with with			71720			21014	1					•			
hs 2;	Funeral	338 Harlan Sc	12. Was Deced		13. V	vas Decedent of	Hispanic Ori	igin? (Spe	ecify Yes or N		JSA 14. Race - Ame	erican Indian,			
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nal";	d by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dat		'	□Yes 2□N	Specify:				Specify: W	hite			
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Hygie Hygie Int, III		12 17. Father's Name (First, Middle,	l act)		Sa.	lesman	18 Mothe	er's Name	(First, Middle			n Equip	ment		
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2 should be filed withing and Mental Hygiene. is marked other than aumatic event, I	2	William Jacks 19a. Informant's Name/Relations			19b. Mailin	a Address (Stree				annie Dockery Route Number, City or Town, State, Zip Code)					
and 2 sealth an n 27 is		Gina VanDetta				,					and, 21				
S 1 ar of Heg	1 8	20a. Method of Disposition		20b. Plac		sition (Name of natory or other p			ate		ocation - City or				
Pages nent of int: If it		1 Burial 2 □ Cremation 4 □ Donation		ate				11/1	2/2009	Fa	11ston.	Marylar	bo		
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic enonce.	. 1	21. Sign fre of Fill ratific type Lip-see 22. Name and Address of Facility McComas Funeral Home, P.A.													
Balas		50 W. Broadway, Bel Air, Maryland 21014													
		23a Part 1. Enter the disease, or shock, or heart failure. List	r complications that cau	used the death.	Do not ente	er the mode of d	ying, such as	cardiac o	or respiratory	arrest,		Approximate Interval Betw	/een		
Physician	9	Immediate Cause (Final disease or condition			00	SN (CA	2	C13	R		Onset and D			
/Medical		resulting in death)	Due to (o	r as a consequer	nce of):										
Examiner	L	Sequentially list conditions,	b												
led isit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (o	r as a consequer	nce of):										
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requires that the death certifications is a second to the second to the attending it hould be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnand] Ectopic pregna	nov				23d. Date of de		- 1		
deat he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of dea		Other (specify)					Month	Day Y	ear		
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requii een s	ted									Yes 2	3 □ P	robably 4 □ U	TIKHOWH		
aw as t	ompleted								24a. Wa aut	opsy	prior to	utopsy findings a completion of ca			
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Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				ther:		(Check only						
Jing Phys After this funeral dii	5.	1 Yes 2 No	1 ☐ In		R/Outpatien 8b. Time of	L 3 L DOA	4 🗀 🕅		me 52 Re 28d. Describe		6 ☐ Other (Spe	ecify)			
ding h. After fune	ţ	1 Natural 5 □ Pendir 2 □ Accident investi	ng (Month	, Day, Year)	Injury	28c. In W	ork? □Yes 2□		Lou. Docomb	5 110 17 11 Ju	ny cocamoa				
Attending r death. ector: After by the fune	fica	3 Suicide 6 Could	not be 28e. Place o	f Injury - At hom	e, farm, str							ural Route Numb	per,		
alor s after od in b	Certification:	4 ☐ Homicide determ	building	g, etc. (Specify)					City or I	own, Stat	e)				
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (ng Physician: To the b Examiner: On the bas and manne	sis of examinatio											
To the I	Mec	29b. Signature and title of certifie		oraceu.		29c. Lice	nse number			29d. Da	ate signed (Mon	th, Day, Year)			
		1	PH	ISTER	LAN	D	005	84	75	NON	JENBI	3211	2009		
7.		30. Name and address of person	who completed cause	of death (Item 2	23a) (Type,	Print)									
		PHILIPN	JUATPU	msh,	602	ATM	0 O	ROA	O, Di	30	ARR,	mD 21	014		
Sta Registi		31. Date filed (Month, Day, Year)	009 Jens	gistrar's Signatui	ne par	Col									
								_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of Ma	aryian	Cer	tificate of	neaith an Death	a Mental Hy	giene Reg. No.	2009	36225			
Physi Me	iciar edica		Decedent's Name (First, Middle, Last EDYTHE	т) М.			DWORK I	N	2. Date of De Month NOVEME	Day	. 2009	3. Time of Death 7:10 A M			
Exar		er	4a. Facility Name (if not institution, give GILCHRIST HOSPICE				4b. City, Town, o			4c. (County of Death				
Funer Direct			213-00-0925	х м 2 X) F	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Nin. 02-28-	th 1951	9. Birth Coun	place (State or Foreign htry) MD			
aryland a-f show ied at		Director	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE	:	,	, Town or Loc						10d. Inside City Limits			
h the Ma ka or 28a be notif		al Dire	10e. Street and Number			LISILK	10f. Zip Code			10g. Citiz	zen of What Cour				
eath wit tems 23 er must		Funeral	409 VALLEY MEADOW 11. Marital Status	12. Was Decedent E		. 13. W	21136 Vas Decedent of I	Hispanic Origin?	(Specify Yes or No- uerto Rican, etc.)	USA 1	4. Race - Americ	can Indian,			
ire, Maryland 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked outher than "natural", or items 23a or 28a-f show offen traumatic event, the Medical Examiner must be notified at.	Ü	<u>۾</u>	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates.	No		Yes, specify Cub		uerto Rican, etc.)	1	Black, White, Specify: WHI				
Z13-1 in 72 hor e. ian "nat Medice	Ì	Completed	15. Decedent's Ed (Specify only highest gra		+)	(Give k	ent's Usual Occu ind of work done ONOT use retired	during most of	working	16b. Kir	nd of Business In	dustry			
iled withi Hygiene other th	8	Be C	Elementary/Seconday (0-12) 12 17. Father's Name (First, Middle, Last)		,,	Cl	ERICAL	18 Mother's	Name (First, Middle,		TLER OPT	ICAL			
Iryland ould be filed id Mental Hy marked oth		- 1	BERNARD		WORK:	IN		GILDA		Walden O		PNICK			
Maryl d 2 should alth and Me 27 is mar			19a. Informant's Name/Relationship (Ty) MOLLIE J. SACHS/CO			1			Rural Route Numbe			Code)			
IMOFE, Page 1 and nent of Heal ant: If item 3			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	CE	lace of Dispos	sition (Name of natory or other pla	ce)	Date	20c. Loc	cation - City or To	,			
baltimore permit. Page 1 a Department of H Important: If ite any injury or ott	опсе.		21. Signitury of Funeral Service (cens 22. Name and Address of Facility SOL LE 8900 REISTERSTOWN ROAD								09 BALTIMORE, MD VINSON & BROTHERS, INC. , PIKESVILLE, MD 21208				
Physicia			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death)									Approximate Interval Between Onset and Death			
Medic Examin	_		resulting in death)	a. Due to (or as a			CITTON					***			
ited d ansit		aminer	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury	b. Due to (or as a	consequ	ence of):									
icate be executed physician and the burial-transit		ical Ex	that initiated events resulting in death) Last	Due to (or as a	consequ	ence of):									
DIVISION OF VICES THE HOSPITAL OF A THE HOSPITAL OF THE HOSPITAL OF THE HOSPITAL OF A THENDING PHYSICIAN: The law requires that the death certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the I		Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 🔲 Fetal	death 3	Ectopic pregnar Other (specify) _	су		2	3d. Date of delive	ery Day Year			
us, r.C. quires that the signed by all do deta	.	≥	Part II. Other significant conditions co	ntributing to death bu	it not resu	ulting in the ur	nderlying cause g	iven in Part I.	23e. Did to			ne cause of death?			
The law requirer ate has been signage 2 should be		Completed							24a. Was auto perfo 1 Yes	osy ormed?	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings available mpletion of cause of			
sician: scertific lirector,	- -	lo Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	0 D I	ED (O. t ti t	Oth	lace of Death (C	Check only one)		,				
Attending Phy death. ctor: After this			27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	у	ER/Outpatient 28b. Time of injury	28c. Inju wor	ry at	28d. Describe h			HODICE			
DIVISION Atterments at Directored in by the		Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.			et, factory, office		28f. Location (S City or Tox		Number or Rural	Route Number,			
ne Hospi n 24 hou ne Funer pleted fill		Medical	29a. Certifier (Check only one) 3 Certifying Physical Examination (Check only one) 3 Certifying Nurse		amination	and/or investi	gation, in my opin	on, death occurr	red at the time, date a	ind place, a	and due to the car	use(s) and manner stated.			
To the With Common			29b. Signature and title of certifier	-On- CP	Gia		29c. Licens	e number	2	29d. Date	signed (Month, I	Day, Year)			
			30. Name and address of person who co	ompleted cause of de	ath (Item	23a) (Type, Pr	int)	~~~	River	Ta: -	on M	Lancel			
S Regis	tate stra		31. Date filed (Month, Day, Year) NOV 1 2 2009	32. Registrar	's Signatu	ire back	- A	· · · · ·	, JIW	icu.	21110	70007			

		•	For State Of IVIAN State Registrar	Cer	tificate of D	eaith and iv eath		giene 200	9 36226			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death			
	Medic Examin	al	Elaine P. Esposito 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L		Novembe	r 7,2009 Yea	1:14p M			
	- LAAIIIII	CI	Gilchrist		Towso				alto.			
	Funeral			In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9.1	Birthplace (State or Foreign			
	Director		217-38-9696 GE GE GE GE GE GE GE G	3 Yrs.	World S Bay 5	TIOUTO IVIII.	July 17	,1941 Ma	ountry) aryland			
	and show lat	or		0c. City, Town or Loc	ation				10d. Inside City Limits			
	Maryla 18a-f	rect	Md. Balto.		Perry Ha	11			1 ☐ Yes 2 🔀 No			
	a or 2	ID I	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?			
	th witl ms 23 must	Funeral Director	4910 Silver Spring Rd.		21128			USA				
'	or ite		11. Marital Status 1 ☐ Never Married 2 ▼ Married 12. Was Decedent Everores? 1 ☐ Yes 2 ▼ No.	If	as Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Ar Black, WI	nerican Indian, nite, etc.			
93	rs afte ral", o Exan	Completed by	1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ★ No. If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Specify: Wh	nite			
2-0	2 hou "natu	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupat	tion tring most of working	na	16b. Kind of Busines	ss Industry			
7	thin 7	Som	Elementary/Saconday (0-12) College (1-4 or 5+)	life. DC	NOT use retired) okkeeper	ang mode or worth	···9	Accounti	ing			
0 0	led wi Hygie other ent, ti	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	s Name (First, Middle, Maiden Surname)					
lan	l be fil fental rked tic ev	욘	Leonard A. Karczeski				Dorothy Appel					
ary	should and N is ma auma		19a. Informant's Name/Relationship (Type, Print)		_	nd Number or Rura	l Route Numbe	ute Number, City or Town, State, Zip Code)				
<u>√</u>	und 2 s lealth im 27 her tra		Paul Esposito Sor	n 1915 20b. Place of Dispos	Castle R	Rd. Fore	st Hill	, Md. 2105				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20c. Location - City							
븚	nit. Pa artme ortani injury	- 4	4 Donation 5 Other (Specify)									
Ba	Dep Imp any one		21. Signature of Euneral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236									
			23a. Part 1 Enter the disease, or complications that caused the shook, or heart failure. List only one cause on each line.	e death. Do not enter	r the mode of dying,	, such as cardiac o	r respiratory arr	est,	Approximate Interval Between			
F	nysician/	3	Immediate Cause (Final disease or condition	d conci	25				Onset and Death			
	Medical Examiner		resulting in death) Due to (2) as a c	onsequence of):	2.07							
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a c	onsequence of):								
	uted id ansit	ami	Cause (Disease or iinjury that initiated events c.									
	e executed sian and urial-transi	al Ex	resulting in death) Last Due to (or as a c	onsequence of):								
1,00	certificate be executed nding physician and use as the burial-transit	Physician/Medical Examiner	d									
89	certific nding use as	n/M	IF FEMALE: 23c. If yes, outcome of					23d. Date of	delivery			
Box	death he atte	sicia	in the past 12 months? 1 Yes 2 No 1 Pregnant at till	Fetal death 3 me of death 5	Ectopic pregnancy Other (specify)			Month	Day Year			
0	it the c l by th stache	Phys	9 LI ORKROWN			- in Do Al	1					
ري ح. ا	s tha	þ	Part II. Other significant conditions contributing to death but	not resulting in the ur	idenying cause give	mm Part I.	23e. Did to		to the cause of death? Probably 4 □ Unknown			
ğ	requir been s	letec					24a, Was a	<u> </u>	autopsy findings available			
Vital Records,	he law te has age 2	Completed					autop perfo	rmed? prior t death	o completion of cause of ?			
a l	ian: Ti rtificat ctor, po	Be C	25. Was case referred to medical examiner?		26. Plac	ce of Death (Check	1 \(\superstack Yes\)	2 A No 1 L	∕es 2 □ No			
֓֞֞֞֝֟֝֟֝֟֝֟֝ ֡	hysic this ce al direc	မ	1 ☐ Yes 2 No 1 ☐ Inpatient	2 ER/Outpatient	3 DOA Other:	: 4 ☐ Nursing Hor	me 5 Resid	ence 6 XOther (Sp	ecify) 40501Cb			
O	ding F h. After funera	ate	27. Mainer of Death 1	(ear) 28b. Time of injury	28c. Injury a work? M 1 \sum Y		28d. Describe h	ow injury occurred	·			
Division of	Atten r deat sctor: by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury	- At home, farm, stree			28f. Location (S	treet and Number or F	Rural Route Number,			
2	talor rs afte al Dire ed in l		building, etc. (\$	Specify)			City or Tow	n, State)				
	Hospi 24 hou Funer sted fill	Medical	29a. Certifier (Check (mination and/or investi	gation, in my opinion	, death occurred at	the time, date a	nd place, and due to th	e cause(s) and manner stated.			
:	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	Σ	only one) 3 Certifying Nurse Practioner: To the beau 29b. Signature and title of certifier	st of my knowledge, de	eath occurred at the t 29c. License r			e cause(s) and manner a 29d. Date signed (Mor				
	, , , ,		Whocea Tomora C	ENP	RK453	556	- 1	Jacans	2 7,2Y79			
`			30. Name and address of person who completed cause of deat				`					
	0		Kelbole Vitula 555 U 31. Date filed (Month, Day, Year) 1/32. Registrar's		auson-	town 7	Sud	aison,	MO 31304			
	Stat Registra	_	MINV 3 2 2009 Sente	B. park								

11.09.09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and 4c. County of Death 4b. City, Town, or Location of Death Examiner Fallstaff Ballimore NA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **96** Yrs. 8 Date of Birth **Funeral** (Yrs. Director 10c. City, Town or Location 10d. Inside City Limits ra", or items 23a or 28a-f sho Examiner must be notified at Completed by Funeral Director Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with ISA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ₩idowed 4 Divorced "natura" Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4140 Fallstaff Rd. Baltinore, MD 21215 Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-18-2009 Sharon Hill PA 19079 4 Donation 5 Other (Specify) Name and Address of Facility Quehn C. Greent Puneral Stu 21. Signature of Funeral Service Licer iherty Ros ndallstorn, MDZ1133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death INFARCAM Physician/ MYO CAMPIAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MILVIN To Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Luc to for as a consequence on signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Yes P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dements Records, 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/1 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **Certificate:** 1 Natural 2 Accident Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 033974 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 24 J mys

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #1 ner MD 9897 11/17/09 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 36228 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Earl Alvin Edmondson 9:37am Earl Elvin Edmondson November 8, 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1316 Lee Lane Sykesville Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ∏ M 2 □ F Director 219-34-4609 26, MD Nov. 1936 Usual Residence of Decedent 10a. State 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examinar Hust be notified at MD Director Carroll Sykesville 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Lee Lane Completed by Funeral 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐Yes 2√☐No Specify Specify: White 3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ra any injury or other traumatic event, the "sed once. than " Elementary/Secondary (0-12) College (1-4or 5+) Plaster Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Lewis Edmondson Eleanor Clingman ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl J. Edmondson (Son) 263 N. Springdale Road Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Providence Cemetery | 11/12/2009 | Gamber, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee HAIGHI FUNERAL HOME & CHAPEL, P.A. Haugh 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ata /Medical Due to (or as a consequence of): Examiner Colgrasi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence burial-transit Due to (or as a consequence of) Physician/Medical the attending p as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of peath? 2 udema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

ohysician

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and man

29b. Signature and title of certifie 6

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person with ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

James

Progress Way # 114, Electron, we

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Glen Foy, Sr. 2009 36229 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 9, 2009 1545 hrs **Medical Examiner** William Glenn Foy, Sr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel 174 Virginia Avenue Apt. E Glen Burnie If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 243-88-7686 11/10/1952 1 X M 2 F North Carolina Vrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Yes 2 X No 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 222, ----injury or other transmits. Glen Burnie Maryland Anne Arundel Director 10g. Citizen of What Country 10e. Street and Numbe 10f. Zip Code 174 Virginia Ave. United States 21061 Apt. E Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes f Yes, Give Year 4 X Divorced Yes 2 X No specify: Specify: Black 3 Widowed ≥ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed National Gallery Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 yrs. Security Guard of Art 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janie McMillan Robert Foy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Eugene C. Foy /Brother 5501 Park Road Brooklyn, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State X Burial 2 crematory or other place) Cremation 3 Removal from State 11/17/2009 | Spring Lake, NC Sandhills State Vet. Donation 5 Other Specify: 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD21061 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical ttending physician are use as the burial -UNPENDED AMENDED The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 Yes 2 No 3 Probably 4 V Unknown Chronic Alcohol Abuse; Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 Nα 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 24 hours after death.

Certification:

Medical

2

3

the Director:

To the 1

1 V Natural

Accident

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day, Year,

Pending

Investigation

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

Regis

State Registrar DHMH 17 Rev 1/2001

OCME 2006

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Yes 2 No

28f. Location (Street and Number or Rural Route Number, City

November 10, 2009

OCME

29d. Date signed (Month, Day, Year)

or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36230 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Foster Month Physician/ 9:07 AM 2000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 350 Baltimore GWYNN eston 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday Funeral Days Months Min (Month, I 1 🗆 M 2 🗶 F Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Raltimore ()ak CWYNN 1 Tyes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3503 21207 Keston Koad USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 MNo Specify. Specify: Black "natural", 3 XiWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)_ permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Private Domestic 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Colston LAEZ Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin 3503 Keston Road Gwynn Oak, MD 21207 acqueline 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09 Brier Hill, PA afayette Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jaughn C. Greene Funeral Services Randallstown, MD 21133 Vaugh Load 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or ijnjury that initiated events resulting in death) Last Due to (as a consequence of) Physician/Medical P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not less ting in the underlying caus 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b director, page 2 s autopsy performe Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one Be examiner? Other: 2 X No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) After this hin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) NOV aN death (Item 23a) (Type, Print) address of person who completed

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV

egistrar's Signatur

21132

			For State Registrar	State of Ma	aryland /		ent of Hea ate of De		Re	eg. No.ZUU9	36231
	Physici /Medic		1. Decedent's Name (First, Middle, Last	FOWLER					2. Date of Death	Day Year	3. Time of Death 1/36AM
	Examir Funeral Director		4a. Facility Name (If not institution, given Superior Social Security Number 6. Social Security Number 1	an Hospital	e (In yrs. last I 56	E		Under 24 Hrs.	8. Date of Birth (Month, Day, May 4, 1	4c. County of Death N/A 9. Birth County 953	place (State or Foreign ntry) aryland
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location			indy 15		0d. Inside City Limits
	e Mary Ba-f sh tified a	Director	MD Baltimor	e e	Park	/ille					1 □ Yes 2√√XNo
	with th	I Dire	1710 Glen Keith	Rlvd A	ot. D		Zip Code		10	Og. Citizen of What Coul USA	ntry?
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modern Evaminer must be notified at or other traumatic event, the Modern Evaminer must be notified at	by Funeral	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2000 If Yes, Give Year or Dates:	er in U.S.	13. Was De If Yes, s	cedent of Hispa pecify Cuban, N	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
21215-0	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", aumatic event, the Modell Fra	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5 +1		6a. Decedent's L (Give kind of life. DO NO	Isual Occupation work done durin Tuse retired) Sales	n ng most of work	ing	16b. Kind of Business/In Automotive	•
	I be filed antal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last) Joseph Charles N	liller					e (First, Middle, N	•	
Maryland	2 should be fi and Mental I Is marked of aumatic ever	ပ	19a. Informant's Name/Relationship (19	9b. Mailing Addr				City or Town, State, Zij	Code)
	1 and 2 Health em 27 I		Mr. Stephen Fow] 20a. Method of Disposition	er/ Husba		1710 GI			Apt. D	Parkville	
mor	Pages nent of int; if its		1 ☐ Burial ②XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		ceme	tery, crematory of	or other place)	!	2, 2009	Towson, MD	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Sicer	·		00.11	and Address o	f Facility	ck, Inc.	5305 Harfo	rd Rd.
	cate be executed /Medical bhysician and /medical examiner the purial-transit	edical Examiner	23a. Part1. Enter the disease, or compose, or controlled the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each lir	a consequence	254 0 = e of):	e bl				Approximate Interval Between Onset and Death
.O. Box 6	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal dea		ic pregnancy (specify)			23d. Date of deliv Month	ery Day Year
ds, P.	ires that signed b	þ	Part II. Other significant conditions of	ontributing to death bu	it not resulting	in the underlyin	g cause given ir	n Part I.		acco use contribute to t	
of Vital Records,	ician: The law requil certificate has been s ector, page 2 should	Completed							24a. Was ar autops perform	24b. Were auto prior to co death?	psy findings available mpletion of cause of 2 No
V.	lysician: is certific director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital; 1 □ Inpatie	nt 21 DeR/G	Outpatient 3	Other:	_	h <i>(Check only one</i>	e) nce 6 □Other (Speci	
Division of	attending Phi death. ctor: After thi y the funeral (Certification: T	27. Manner of Death 1 Deatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Day	ry (, Year) 28b	Time of Injury	28c. Injury at Work? 1 □ Yes		28d. Describe ho		
Div	lo the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by t		4 Homicide determined	building, etc	(Specify)				City or Town	, State)	, in the second
\	le Hosp n 24 hou le Fune pletely fi	Medical			examination					ause(s) and manner as a ate and place, and due t	
	Vithii To the Comp	M	29b. Signature and title of certifier				29c. License nu			9d. Date signed (Month,	
			30. Name and address of person who	completed cause of de	eath (Item 23s	a) (Type, Print)	H006	8996	Atria C	lovember Te R home, mo	NTH, 2009
			Patricia Eugen	e, Dia.	560	(Cock	2 Rave	on Blu	rd But	home mo	
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. degistra	r's Signatur	A Corre	000		,		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 36232 Certificate of Death Reg. No. 1. Decedent's Name, (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** eanor 8.40pmm 2009 Josephine 16 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Carrol TMINS 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1□M 2□F 217-50-3192 81 Director Sept. 18, 1928 Canada Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Evan in stringst tear office at Yos 2□No Director MD Carroll Svkesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7353 Spout Hill **IJSA** Funeral Road 21784 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-บบ36 1 ☐Yes 2√2 No þ. Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Mears Reta Dolby ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is oury or other trau Mr. Leo F. Fiander (Spouse) 7353 Spout Hill Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springfield Cemetery 11/10/2009 Sykesvile, MD 21. Signature of Funeral Service Licensee PALENT FUNERAL HOME & CHAPEL Parge Harght of PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): as the burial-trar that initiated events resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hast ipidemia page 2 s autopsy perforn certificate 2 **X**No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours are to the Funeral Director: Aff 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. fol 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 208 Washington Kris tian

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 2 2009

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2009 36233 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death P^{Day}1, Physician NOVEMBER GRACE AGNES FOBLE 2009 7:15 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NICHOLS SHELTERED HOME FOR THE ELDERLY **EDGEWOOD** HARFORD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1 □ M 2**X**□ F 219-18-6980 Director 5/9/1925 New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 Is marked other than "natural", or flems 23a or 28a-f shor traumatic event, the Modeal Experience aust by confined at 1 ☐ Yes 2 X No Director MD HARFORD FOREST HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2918 GRIER NURSERY ROAD 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 No Specify. Specify: WHITE Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) REGISTERED NURSE HEALTH CARE YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GERARD STEIB ANNA RENZ 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 I CAROL FOBLE/DAUGHTER 2918 GRIER NURSERY RD. FOREST HILL, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. DULANEY VALLEY MEM Burial 2 ☐ Cremation 3 ☐ Removal from State 11/14/2009 | COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) **GARDENS** 21. Signature of Funeral Service Licensee MO0217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Colitis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner gastro enteritis Sequentially list conditions, any and the list cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit dehydration resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the a 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 ? autopsy performed? 1 □ Yes 2 **X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 STSTED LIVING 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Funeral C 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 29c. License number

00043909 29d. Date signed (Month, Day, Year)
November 11, 2009 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephanie Linder 902 Averill Rd Loppa, MD 21085 31. Date filed (Month, Day, Year) Registrar's Signature State 2 2009 Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 19a per in, g897, 11/12/09dhb Health and Mental Hygiene Certificate of Death 36235 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 2009 8:15 A M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 5906 PARK HEIGHTS AVENUE, #502 BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🗶 F Months Days Hours 214-94-4489 Director 95 10-30-1914 UKRAINE Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygene. Important: If flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Madical Exprins. Thus to notified any injury or other traumatic event, it. Madical Exprins. MD N/A **BALTIMORE** 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5906 PARK HEIGHTS AVENUE, #502 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify <u>Ş</u> Specify: 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BORUCH ABRAMSKY KHANA KOLOMENSKAYA ျှ 19a. Informant's Name/Relationship (Type. Print)
BETYA - GOLDBERG/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 COYLE ROAD, #209, OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 11-08-2009 BALTIMORE, MD 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. Signatu 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** cemene disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical the attending ph IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) the detached 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by NO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 2 □No 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home SPEResidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Inpatient ၉ this 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 ☐ Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.0. Records, Physician: The Division of Vital Hospital or Attending

Maryland 21215-0036

Saltimore,

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and

certifie

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month), Day, Year)

State of Maryland / Department of Health and Mental Hygiene 36236 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 1:15A. M 2009 Willie James Goodman Nov. /Medical Season's Hospice@Northwest Hospital RandalIstown 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours Min. 1⊠M 2□ F Director 212-46-2266 Oct. 16, 1945 S. Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Pikesville Maryland Baltimore 1 ☐ Yes 24 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 21208 8328 Streamwood Drive items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★□Yes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 🖾 No Specity. Specify: Black ò 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specity only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Processing Manager Years Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, If once. Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernice Goodman John Simpkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8328 Streamwood Drive Pikesville, Maryland 19a. Informant's Name/Relationship (Type. Print) wife Masolina Robinson-Goodman 21208 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/14/09 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Greenmount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 165 Diratory disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown an cer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Saws ITOSPICE Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No illed in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

29b. Signature and title of certifie

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Buton 5401 OLD COUNT Rd

29c. License number

29d. Date signed (Month, Day, Year)

Randallstown MD

November 3 2009

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. amend #15ate of Maryland, Department of Health and Mental Hygiene 09-08485 Maurice Gershberg 2009 36237 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 2, 2009 0408 hrs **Medical Examiner** Maurice Gershberg 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 5701 Rubin Avenue If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min Director Mar 20, 1924 Maryland 220-12-2893 1X M 2 85 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 'n 10a, State 10h. County Yes 2 No 28a-f show , or items 23a or 28a-f shov r must be notified at once. MD **Baltimore** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country 10e, Street and Number 10f. Zip Code 5701 Rubin Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married 2 Married 1 X Yes 2 Nο Yes 2 X No specify: If Yes, Give Year Specify: white Divorced Widowed 43-46 marked other than "natural", event, the Medical Examiner ş Decedent's Usual Occupation (Give kind of work done unled) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Cab Driver Transportation 0 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Koenigsberg Frank Gershberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is man Harold Cohen/brother in law 5701 Rubin Avenue Baltimore, MD21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) or other 2 Burial Cremation 3 portant; 4 X Donation 5 Other Specify Ronal Ld S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Wade Director MD 21201 Raltimore Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ilure. List only one cause on each line /Medical Death Contact Gunshot Wound of Head immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. 23d. Date of deliven IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter 1 Yes 2 No 9 Unknown g Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical director, Be Hospital: 1 Other: Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient DOA 2 1 Yes funeral 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Subject shot self FOUND: 1 Natural Yes 2 ✔ No Pending To the Funeral Director: the Nov 2, 2009 0350 hrs 2 Accident Investigation completely filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗹 Suicide Could not be or Town, State) 5701 Rubin Ave, Baltimore, **M**D determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 2, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day Yea 32. Registrar's Signature State Registra

OCME

State of Maryland / Department of Health and Mental Hygiene 36238 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVonth 10 Day 200 gear **Physician** 7:40 P M Frances J. Groves /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springhouse at Westwood Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 😾 F 220-38-2692 92 5, 1917 Washington D.C. Director Sept. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20816 5101 Ridgefield Rd. United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No White Specify: 3 ₹ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Jewell, Sr. Frances ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol M. Dietrich / Daughter 5028 Gadsen Dr., Fairfax, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 11/12/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) RENAL FAILURE MONTHS /Medical Due to (or as a consequence of): Examiner **EMPHYSEMA** YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
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9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Dav Year 5 Other (specify) the 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🗆 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) D39456 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9123 Kirkolale Lita MD 32. Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

36239

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other tranumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physici /Medi Examir

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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uneral rector		5. Social Security No. 578-66-9		6. Sex 1 → M 2 □ F	7. Age (In yrs	s. last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	Min. J	Date of Birth (Month, Day anuary	Year)	9. Birt 1944 Co	chplace (State or Foreign Duntry) Spain
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item		20a. Method of Disp		-		. Place of Disp cemetery, cre	osition (Na	me of	ne)	Nov . Date	7,	20c. Lo	ocation - City or	Town, State
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Importa any Inju once.		21. Signature of Fu	ineral Service	Licensee	MO(Cremati Maryland	ion Service d 20910
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		30. Name and add		h who completed ca	use of death (It	tem 23a) (Type	, Print)		- 0		11722	83	BALTE	M) 2120
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 8, 2009 Medical Examiner Ginski 1245 hrs Eleanor 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1010 South East Avenue **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Mary Land **Funeral** Months Days Hours Min. Nov 8,1925 Director 219-18-6644 84 м 2^X F Country) Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10h County Baltimore City Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other crammatic event, the Medical Examiner must be notified at once. Md. 1 XYes 2 No Direct 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 1010 South East Avenue 21224 U.S.A. Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes White If Yes, Give Yeer 3 Widowed 4 X Divorced Yes 2X No specify: Specify δ. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6th Assembly Line Can Company Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Holewinski Andrew Grutkowski Antonina Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine G. Welkie/daughter 301 Elrino Street Baltimore, Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State November 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 13, 2009 Baltimore, Maryland St.Stanislaus Cem Donation 5 Other Specify 22. Name and Address of Facility (aczorowski Funeral Home, FA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Discase or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** signed by the attending physician be detached for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown q Linknown <u>Р</u> 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ₽. 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic Cardiovascular Disease Completed Division of Vital Records, After this certificate has been s funeral director, page 2 should 1 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 V Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other 4 Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 ✔ Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject fell down steps FOUND: 1 Natural Pending 1 Yes 2 ✔ No the Hospital or Attend To the Funeral Director: completely filled in by the Nov 8, 2009 1237 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 1010 S. East Ave, Baltimore, MD determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b/Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 9, 2009 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 2. Registrar's Sign State Registrar

State of Maryland / Department of Health and Mental Hygiene 36241 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year tephen GOVSKI 2:15 PM November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mercy Medical Center Baltimore Bulhmore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Vear) 1 XM 2 ☐ F Director 212-48-2319 62 Dec30,1946 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore City Director 1KTYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2616 Fleet Street 21224 U.S.A. by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 24 ☐ No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IT Supervisor Cadmus Communication 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Gorski Stella ပ Worbelow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Gorski (wife) 2616 Fleet Street Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November permit. Pages 1
Department of F
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12, 2009 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Kaczorowski Funeral Home, PA Robert 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Attending Physician: The law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2. No Certification: To 11 Impatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital or 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier **Medical** (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P24 350 NEMBER 7, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sessa he Bulhmore MD 21230 12988 31. Date filed (Month, Day, Year) NOV 1 2 2009 State Registrar

09-08679 Johnnie Hawkins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2009 3624 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3. Time of Death											
Physician/ fedical Examiner	1. Decedent's Name (First, Middle,Last) Johnnie H. Hawkins	3	Month Day Year November 8, 2009	0750 hrs								
	4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Deat N / A S. 8. Date of Birth (MM/DD/YYYY) 9. Bi									
Funeral Director		If Under 1 Year If Under 24Hrs Months Days Hours Min	- I Eoroi	ign ountry) MD								
iow any	Usual Residence of Decedent	ation cimore		10d. Inside City Limits 1 X Yes 2 No								
ith the Maryland 23s or 28s-f show notified at once.	10e. Street and Number 3501 Richmond Avenue	10f. Zip Code 21213	10g. Citizen of What Co	untry?								
or items	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:		ack								
5-0036 led within 72 hours after Hygiene. to other than "natural", the Medical Examiner Completed by I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind of most of working life. DO NOT use re-	work done 16b. Kind of Business tired)	s/Industry								
5-0036 led within Hygiene. other tha the Media	11th Grade Auto 17. Father's Name (First, Middle, Last) Perry Hawkin		Own Car e (First, Middle, Maiden Surname) e Mae Burwe									
AD 2121 2 should be fill 1 and Mental F 27 is marked matic event.	19a. Informant's Name/Relationship (Type, Print) Chiquetta Hawkins (wife) 19b. Ma 350	ing Address (Street and Number or Richmond Ave	Rural Route Number, City or Town, Sta ., Baltimore, M	D 21213								
Baltimore, MD 2121 permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, To Be	1 K Burial 2 Cremation 3 Removal from State King M	osition (Name of cemetery, other place) Em. Park 11	Date 20c. Location - City Baltimo									
Balt permit. Depart Import injury	21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that caused the death. Do not enter	n Jr. Funeral H Ave., Balto.,	Approximate Interval									
Physician Moical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Between Onset and Death									
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
y y oe executed cician and mial - transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.											
te be executed ysician and burial - transit			23d. Date of deliv	/ery								
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be as fler edge. After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buriteration: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 Ectopic preg	nancy Month	Day Year								
P.O. B es that the diggred by the detached		he underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 ✓ No 3 F									
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach on To Re Committed by P.												
tal Recian: Ti	25. Was case referred to medical	26.Place of Death (Cher		41								
of Vit ling Physic After this of funeral dire	1 Vyes 2 No impatient 2 Ervoupa	of Injury 28c. Injury at Work?	sing Home 5 Residence 6 O 28d. Describe how injury occurred Subject shot	ther:								
Division o spital or Attending nours after death. neral Director: After filled in by the fune	7 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 1 Nov 7, 2009 28e. Place of Injury - At home, farm, (Specify) Car Wash		28f. Location (Street and Number of or Town, State) 129 South Payson Street, Baltin	r Rural Route Number, City								
the Hospi hin 24 hou the Funer inpletely fil		occurred at the time, date and place, a tigation, in my opinion, death occurre	and due to the cause(s) and manner as	stated.								
The state of the s	29b Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed November 9,									
	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examine	r 111 Penn Street, Baltim	nore, MD 21201									
Stat Registra	e 31. Date filed (Month, Day Year) 32. Registrar's Signature	COLOR ACTION ACT										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10 f & 18, per FH 989/11/12/09 TT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Vear 12:40 PM arpei NITING 2009 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Son Secours attimor 6. Sex ★□ M 2□ F 8. Date of Birth (Month, Day, Year) 3-15-1958 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 216-74-2768 **Funeral** Min. 51 Months Days Hours Yrs. Md. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c City Town or Location Baltimore 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Md. 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21215 "natural", or Items 23a or 4022 Haywood Ave. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural"; or Health injury or other transmatch. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No 7 If Yes, Give Year or Dates: Specify Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Printer Printer Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Steven Harper Dorothy Black ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Royta Number, City or Towa, State, Zip Code)
4022 Haywood Ave. Balt Illiore, Mg. 21215 Kinya Kiongozi/Brother 20b. Place of Disposition (Name of cametery, crematory or other place)
Ardent Cremation 20a. Method of Disposition 20c. Location - City or Town, State Date 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11-10-2009 Hanover, Md. 22 Name and Address of Facility Phillip A. Weatherford F.S 2431 E. Oliver St. Baltimore, Md. 21213 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Persis day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leaf cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician at the burial P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 [funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Datural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie

DHMH 17 Rev 1/2001

State Registrar 2000

32. Ragistrar's Signature

WBaltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

labatasa

			For State Registrar	State of Ma	-	artment of H		nd Mental Hy	giene Reg. No 20	09	36244
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea	ath	Vee	3. Time of Death
	Physici /Medi		Betty Mae Hold	en					er 3, 20	Ye ar 109	7:55 AM M
	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of	Death	4c. County	y of Death	1
			15 Gwynn Lake			Balti		dila la mana			
-	Funeral			Sex 7. Ag 1 □ M 2 ☑ F	e (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	Hours 2	Min. (Month, Da	th ly, Yea <i>r)</i>	Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent		68 Yrs.			Feb 18,	, 1941	Mar	yland
	yland		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	r 28a-f show	ctor	MD		Baltimo	re					1 Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
	hours after death with the Maryland tural", or items 23a or 28a-f show all Examiner must be multiple at	Funeral Director	15 Gwynn Lake Dr	ive		212			US	SA	
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces? 1 ∐Yes 2 🛣	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Ra Bla	ce - Ameri ck, White,	ican Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3X☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No	1∐Yes 2 X ∏No	Specify:		Specit	y: bla	ack
21215-0036	hour	ed	15. Decedent's E		16a. Dece	dent's Usual Occup	ation		16b. Kind of B	Susiness/Ir	ndustry
215	nin 72 e. In "nat	plet	(Specify only highest gi Elementary/Secondary (0-12)		(Give	kind of work done on DO NOT use retired	durina most	of working			
21	e filed within al Hygiene. I other than " went, In We	ĕ		ınk	77)	disa	abled		n	one	
pu	be filed within 72 hours after death with that Hyglene. ed other than "natural", or items 23a o event, the Medical Event exert.	Be Completed	17. Father's Name (First, Middle, Las	t)		unk	18. Mother	's Name (First, Middle,	Maiden Surnar	me)	unk
Maryland	2 should be and Menta is marked aumatic ev	은									
Nar	l 2 sh h and 7 is rr traum		19a. Informant's Name/Relationship			,		r or Rural Route Numbe			
	1 and Health Sm 27 ther t		William Campbell 20a. Method of Disposition	/brother				Road Randa	11stown 20c. Location		
Baltimore,	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		1 ☐ Burial 2 ☐ Cremation 3 [20b. Place of Dispo cemetery, crei	natory or other plac	e)	Date	200. Location	- City or i	own, State
語	it. Partment injury		4 Donation 5 Other (Spec		200	Name and Addres	e of Eacility				
Ва	permit. Departr Importa any inju		21. Signature of Funeral Service Line Ronald S	Wade, Mir	<i>21 /</i>		-	Board 655 W	. Balti	more	Street
			23a. Part I. Enter the disease, or co	plications # at caused	the death. Do not ent	Baltimore ter the mode of dyin		21201 cardiac or respiratory a	rrest,		Approximate
	Physician		shook or heart failure. List only Immediate C Final	one cause on each li	ne.	(0)	S	,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	c-> 1/11	OC CC			-	Yours
	Examiner				stive.	Heart	Fai	ure			Young
	₽ #	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	U.	a consequence of).		1				
	ecute ind transi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
90,	cate be executed physician and the burial-transit	Ĭ	resulting in death) Last	Due to (or as	a consequence of):						
8760,	cate b	dical		d							
9 x	leath certific attending p	Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnanc	у			ate of delivented	very Day Year
Ö	the de	Physician/Me	1 □ Yes 2-□ No 9 □ Unknown	9 ☐ Unknown	t tillle of death 5 L	Other (specify)					
σ.	ician: The law requires that the dicertificate has been signed by the rector, page 2 should be detached	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to	the cause of death?
rds	quires n sign ald be	Completed by	Throsed Car	Cer.				1 🗆 1	Yes 2 □ No	3 ☐ Pro	bably 4 🔁 Unknown
00	s bee	lete						24a. Was	an 24b.	Were aut	opsy findings available
Re	The la te had age 2	l E							rmed?	prior to co	ompletion of cause of
ta	an; rtifica tor, p	BeC	25. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only o	2 No	1 ☐ Yes	2 LINO
Y	ysici lis cel direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Oth		sing Home 5 Resid		her (Spec	ify)
0	ng Ph fter th neral	اقا	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	f 28c. Injur Work			how injury occur		
ioi	endir sath. or: At he fu	atic	2 ☐ Accident Investigation	n	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2□N	lo			
Division of Vital Records,	l or Attend after death Director: /	Certification: To	3 ☐ Suicide 6 ☐ Could not lead to determined	28e. Place of Injuding, etc.	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tox		ber or Rui	ral Route Number,
Ω	oital o										
	Hosp 24 ho Fune etely f	Medical			f examination and/or in			d place, and due to the h occurred at the time,			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Mec	29b. Signature and title of certifier	und manner ste		29c. Licens	e number		29d. Date signe	ed (Month	, Day, Year)
	->= O		1			M/	27		112.10.		VI. 2009
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print)	1	<i>)</i>	J-DEM	NEV,	MD 21228
			Deepak BG	Skaran	3455	Wilken	SA	ve LL	10 12H	More	MD 21228
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature						

			For State	State of Ma	aryland	d / Depa <i>Cen</i>	rtment tificate	of H	ealth a eath	and Me	ental Hy	giene Reg. N	e 200	9	3624	5
			Registrar 1. Decedent's Name (First, Middle,	Last)				-	<u> </u>	- 7	2. Date of Dea	ath		Т	3. Time of Death	_
	Physicia Medic			Vernon Lee	e	Holt					Month Novemb	er	7,2009		2:50 A M	1
	Examin	er	4a. Facility Name (if not institution, Stella Maris	,			4b. City, To	,	Location o			4	c. County of De Baltimo		Co	
	Funeral			6. Sex 7. Age		st birthday)	If Under 1	Year	If Under	24 Hrs. 8	3. Date of Birt	h . Vaarl	g. F	Birthpla	ce (State or Foreign	n
	Director		228-16-6087	1 🖾 M 2 🗆 F	87	Yrs.	Months	Days	Hours	Min.	Month, Day Sept.	1,1	922 V	Lrg	inia	_
	at at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation							100	d. Inside City Limits	;
	Maryla 28a-f	rect	Maryland Bal	timore				Ros	sedal	Le		_		\perp	1 ☐ Yes 2XXNo	0
	th the	al D	10e. Street and Number				10f. Zip C		1007			-	Citizen of What			
	ath wi	Funeral Director	5228 King Arth	12. Was Decedent E	ver in U.S.	. 13. W	/as Deceder		1237 Spanic Orio	ain? (Speci	fy Yes or No-	Uni	ted Sta			_
2:50 a.m.	°	Completed by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	No	If	Yes, specify Yes 2	y Cuban	i, Mexican	i, Puerto Ri	ćan, etc.)		Black, Wh	nite, et		
0.0	2 hou "natu edical	plet	15. Deceden (Specify only highes	t's Education st grade completed)		16a. Deced	ind of work	done di		t of working	[4]	16b.	Kind of Busines	s indu	stry	
2:50	vithin viene.	Con	Elementary/Seconday (0-12) 7 Years	College (1-4 or 5-		Assist	NOT use re Gene	,	Fore	eman		St	ceel Ind	dus.	try	
6	filed wall Hyginal Hyg	Be	17. Father's Name (First, Middle, La	•					18. Mothe	er's Name (First, Middle,					
2009 aryland	Menta Menta narked	잍	Delacy Edward			· · · ·			Mar	cy L.	Norvel	1				
7, 7	nd 2 shotealth and m 27 is ner traum		19a. Informant's Name/Relationsh Linda J. Kopaj		er)						Route Number		or Town, State,	Zip Co 212:		
NOVEMBER Baltimore.	Page 1 a ment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		ce	ace of Dispos metery, crem S. of	atory or oth	er place		11/10	te 0/2009		Location - City		n, State Maryland	
NOVE	permit Depart Impor any in	JS.	21. Signature of Funeral Service Li	cefisee	_								undalk, yland			
			23a. Part 1. Enter the disease, or shock, or heart failure. List of			. Do not ente	r the mode	of dying	, such as	cardiac or i	respiratory arr	est,		1	Approximate nterval Between	
	Physician/ , Medical		Immediate Cause (Final disease or condition resulting in death)	a. DEMENTI										<u> </u>	Onset and Death	
***	Examiner			Due to (or as a	conseque	ence of):										
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as a	conseque	ence of):							-			
	cuted ind transit	Examiner	Cause (Disease or linjury that initiated events	c. Due to (or as a										1		
	ate be executed physician and the burial-transit	dical E	resulting in death) Last	bue to (or as a	Conseque	silice oij.										
3760	ficate I g phys	/edi		d			·							土		_
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 4 Pregnant at 9 Unknown	2 🔲 Fetal	death 3	Ectopic pre		4				23d. Date of of Month		/ day Year	
0	hat the ed by detack	y Ph	Part II. Other significant conditio	ns contributing to death bu	ut not resu	Ilting in the ur	nderlying ca	use give	en in Part	I.	23e. Did to	obacco	use contribute	to the	cause of death?	-
	uires t	ed b									1 🗆	Yes 2	2 X No 3 □	Proba	bly 4 🗆 Unknown	n
VERNON HOLT of Vital Records.	ne law req e has bee age 2 sho	omplet									24a. Was autor perfo	osy rmed?	prior t death	o com	y findings available pletion of cause of	
VERNON f Vital R	lan: Th	3e C	25. Was case referred to medical examiner?					26. Pla	ce of Dea	th (Check o		2 X	NO ILL	es z	□ No	
VER Vit	Physic this ce al dire	으	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 Inpatie 28a. Date of injur		R/Outpatien			4 ∐ Ni	-				ecify)	HOSPICE	
	iding I th. After funer	cate	1 X Natural 5 □ Pending 2 □ Accident Investig	g (Month, Day,	Year)	injury	M 280	c. Injury work?			d. Describe h	iow inju	ury occurred			
Division	I or Atter after dea Director d in by the	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be	ry - At hon (Specify)	ne, farm, stre	et, factory,	office		28	3f. Location (S City or Tow	Street a	and Number or i te)		oute Number,	
_	e Hospita 124 hours e Funeral	Medical	(Check 2 Medical E	Physician: To the best of r xaminer: On the basis of ex	amination	and/or investi	igation, in my	y opinior	n, death o	ccurred at th	ne time, date a	nd plac	ce, and due to th	e caus	e(s) and manner stat	ted.
	To th withir To th comp	2	29b. Signature and title of certifier	2 2 4 1 1					number				ate signed (Mo.			
			1 JAM	SCANT			1/2	<14	979	12			11/9/	100	9	_
1			30. Name and address of person v	•				D.	ттмо	MITIM	MD 21	വമാ				
1	Stat		31. Date filed (Month, Day, Year)	CRNP 2300 D 32. Ragistra			DEL K	0	TIMO	MI UPI	ED ZI	373				
1	Registra	ır	MOAT	ZUNY Person	4	B. A.	asse									_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	ertifica	ate of L	Death		R	eg. No.	200	9 3624
Physicia		Decedent's Name (First, Middle,Last)						2. Date of Dea	th		3. Time of Death
Medical Examiner			Catherine d	J. H	utson	1		Month Novembe	Day r 1, 2	009 Year	0705 hrs
		4a. Facility Name (if not institution, give s	treet and number)		4b	. City, Town, or	Location of Dea	ath	40	. County of Death	
		Cristobal				Panama				Out-Of-State	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birth	nday)	If Under 1 Year			rth (MM	/DD/YYYY) 9. Birtl	
Director	ĺ	498-30-4995 1 I	1 ² XX 77		Yrs.	Months Days	Hours N	in. Dec. 2	01 1	931 Foreign	ntryMissouri
		Usual Residence of Decedent	-AA 11				1		-1-	931 -1	
any	- 1	10a. State 10b. County			or Location	٦					10d. Inside City Limits
Maryland 28a-f show 1 at once.	'n	Texas Hildago		McA.	llen					1	1XX Yes 2 No
Maryl 28a-f	Director	10e. Street and Number				10f. Zip Code		1	l0g. Cit	izen of What Coun	try?
th the A		1715 Kendallwood				785	01			U.S.A.	
th with	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	U.S.		Decedent of His s, specify Cuban		Specify Yes or No)-	14. Race - Americ White, etc.	an Indian, Black,
er dea		3 Widowed 4 XXPivorced	1 Yes 2XX No			es 2XX No		,		Specify: W	nite
urs aft	ğ	15. Decedent's Education (Specify only	r Dates:	16a. E	A	Usual Occupat		of work done	16b.	Kind of Business/Ir	ndustry
2 hou "nat	흵	Elementary/Secondary (0-12)	College (1-4 or 5+)		luring mos	t of working life.					,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Completed	12 4			Br	oker			R	eal Esta	te
5-0 led w Phygic othe		17. Father's Name (First, Middle, Last)		•				me (First, Middle,			
De fi	8	Frank Palermo	ACCEPTED.				Beat	rice Cor	ona		
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	유	19a. Informant's Name/Relationship (Type			-	•				City or Town, State,	Zip Code)
MD d 2 sho lth and n 27 is numatic		Donna Sebert (Daug	<u></u>			ndall		ar, MO 6			
Files		20a. Method of Disposition 1 X Surial 2 Cremation 3			f Dispositions of the	on (Name of cer	netery,	Date	20c.	Location - City or	Town, State
Pages sent o		4 Donation 5 Other Specify:	Mt	. 01	livet	Cemete	ry 1	1/13/200	9	Raytown,	Missouri
Baltimore, MD 21215-0 pernit. Pages I and 2 should be filed w Department of Health and Mental Hygi Important: If iten 27 is marked oth injury or other traumatic event, the I		21. Signature of Furreral Service License	e /		22. Na	me and Address	of Facility		7 77	T .	
O 8.0 E E		Muchan (cons	nto		363	Per-lien Falls	Road Road	Balto, M	р н	ome 11 ^{Inc}	
Physician		23a. Part I. Enter the disease, or complication. List only one cause on each		th. Do not	t enter the	mode of dying,	such as cardia	c or respiratory ar	rest, sh	ock, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Ad	cute Peritonitis								Death
			e to (or as a consequence								
		Sequentially list conditions,	uptured Intestinal Di		um						
	<u>.</u>	cause. Enter Underlying Cause Di	e to (or as a consequence verticular Disease	Of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
recuted and and - transit		d									
ox 68760, ant certificate be execut attending physician and or use as the burial - tra	dica	UNPENDED	AMENDED								
760 cate l	§	IF FEMALE:	23c. If yes, outcome of pre	gnancy					23	3d. Date of delivery	
68 certifi	ä	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month D					ay Year				
	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown									
O. B at the de lby the	급	Part II. Other significant conditions co	ontributing to death but not	resulting	in the un	derlying cause g	iven in Part I.	23e. Did t	obacco	use contribute to	the cause of death?

To the Hospital or Attending Physician: The law requires that within 24 hours shafted each.

To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be det Division of Vital Records, P.

Completed by

Be

Medical

25. Was case referred to medical 1 V Yes No 27. Manner of Death

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year) Pending Investigation

2 28b. Time of Injury

ER/Outpatient 3 DOA 28c. Injury at Work?

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc.

26.Place of Death (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nursing Home 5 Residence 6 ✔ Other: Scene

28d. Describe how injury occurred

24a. Was an

autopsy performed? ✓ Yes 2

2 Medical Examiner: On the basis of examination and/or investigati	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
and manner stated.	29c. License number	29d. Date signed (Month, Day, Ye

29d. Date signed (Month, Day, Year) November 9, 2009

28f. Location (Street and Number or Rural Route Number, City

1 Yes 2 No 3 Probably 4 Unknown

1 🗸 Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 No

O.C.M.E.

31. Date filed (Month, Day, Year) State Registrar

Assistant Medical Examiner 32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

1 V Natural

29a. Certifier 1 (Check only one) 2

3

Accident

Suicide

29b Signature and title of

Patricia Aronica-Pollak MD.

30. Name and address of person who completed cause of death (Item 23a)

Could not be

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36247 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Ann D. Hallgren 2009 Nov 11, 7:15A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford <u>Upper Chesapeake Medical Center</u> Bel Air If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Min. 1 □ M 2 🕱 F Months Days Hours 78 579-38-8572 22 - 1931D.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 DYes 2 □ No Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 408 Sassafras Court 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Geneologic Researcher Geneology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Baggett Nichols <u>Morris S. Daniels, Jr.</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Sassafras Ct., Bel Air, MD 21014 <u>Jack Arrowsmith - Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Bayview Crematory 11-12-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S Bradley-Ashton Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Fine) 2134 Willow Spring Road, 21222 mody of dying, such as cardiac or respiratory arrest, Approx Approximate Interval Between Onset and Death Immediate Cause (Final MOCOROLIA r as a consequence of): monary Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

10a. State

MD

Directo

Funeral

≥

Completed

Be

2

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural" ---- any injury or other transactions.

law requires that the death certificate be executed

204

Box 68760

Division of Vital Records,

Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica stelly filled in by the funeral director, p. 24 hours after e Funeral Dire letely filled in b

Medical Certification: To Be Completed by Physician/Medical Ex	Medical Certification
completely filled in by the funeral director, page 2 should be detached for use as the burial-!	completely filled in by the fun
To the Funeral Director, After this certificate has been signed by the attending physician a	To the Funeral Director: Aft
fter death.	within 24 hours after death.

disease or condition resulting in death) Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11-11-2009 s of person who completed cause of death (Item 23a) (Type, Print)

hesapeule Drive, Rd Alv MD, 21014

State

31. Date filed (Month, Day,

500

32. Registrar's S

Upner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #8 per Fh g897 11 17.09 TT

1- For Amend PI line a-b, PII, 25,27 Per ME g902 4/7/10 TT

Certificate of Death

Reg. No. 199 36248 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician 2009 William Stevenson Hudson, Sr. 7:26a November /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Days 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 ₹ M 2 ☐ F 215-16-1363 87 Director March 20281922 PA Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ire I walled Examiner must be notified at MD Director Carroll Sykesville 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 405 Obrecht Road 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ∐Yes 2 X No Black, White, etc. 72 hours after 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗓 No Specify: black þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other tha any Injury or other traumatic event, If all once. cook food service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Hudson Anna Regina Groomes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Colbert (daughter) 619 Greenway Ave., Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State White Rock UMC Cem. 11-16-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Sparget O P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final opiate intoxication **Physician** disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed sician and burial-trans AL EXAMINER Due to (or as a consequence of) Box 68760, CERTIFICATION APPROVED BY Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Vear Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ned by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 2 No Hypertensive cardiovascular disesse 1 Tes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Acute & chronic renal failure 24a. Was an autopsy Mellitus certificate 1 ☐ Yes Division of Vital 3 25. Was case examiner? Be referred to medica 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this Other (Specify 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu unk 1 ☐ Yes 2 X No investigation Fd unk A^M ☐ Accident Fd 11/7/09 6 X Could not be 3
Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fd: 7309 Second Ave Svkesville, MD Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Found Nursing Home Sykesville, 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2☐ Medical Examiner: of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of poon who co (Item 23a) (Type, Print)

Registrar

State

STMINSTER ND 21157

09-Ro

-08599 onald Dean Ha		Please Type or Print in Black Indelible Ink. Ensure All Copi State of Maryland / Department of Health and Mental H			9 3624		
Physicia edical Exami	ın/		2. Date of Death Month November	. No.	3. Time of Death 1004 hrs		
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 8654 Cobblefield Drive Columbia		4c. County of Death Howard			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours M	s. 8. Date of Birth in. June 20	Foreig	thplace (State or in untry) MD		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Columbia 10e. Street and Number 10f. Zip Code 21045	100	g. Citizen of What Cour USA	10d. Inside City Limits 1 Yes 2 No		
	by Funeral L	11. Marital Status 1 Never Married 2 Married 2 Married Forces? 1 Yes 2 No 1 Yes, Sive Year or Dates: 1 Yes 2 X No specify:	to Rican, etc.)	White, etc. Specify: Wh	ican Indian, Black,		
	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 College (1-4 or 5+) 4 Engineer	etired)	16b. Kind of Business/I Northrop G	,		
	To Be Co	Charles Albert Hall Jr. Lois Vi	me (First, Middle, Ma irginia G	reth	Tin Onda)		
		Victoria Hall (daughter) 41 Trudy Ln., Cheekt					
		1 Burial 2 XCremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: All County Cremation 11	7-09	Sykesvill	e, MD		
		21. Signature of Funeral Service Licensee Page House House 22. Name and Address of FacilityHa: P.O. Box 195 Syke 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	esville,	MD 21784	Approximate Interval		
Physician /Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	c or respiratory arres	st, snock, or neart	Between Onset and Death		
on of Vital Records, P.O. Box 68760, ading Physician: The law requires that the death certificate be executed tht. r: After this certificate has been signed by the attending physician and be franced director, page 2 should be detached for use as the burial - transit	lical Examiner	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.					
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last current of the consequence of the conseq					
		d d					
	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1					
ires that the signed by I be detach	ğ			pacco use contribute to	the cause of death? bably 4 Unknown		
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cian: certifi ector,	Be	25. Was case referred to medical examiner?					
Physi er this ral dir	٤	1 Ves 2 No 100-pitel 1 Inpatient 2 ER/Outpatient 3 DOA 100-pitel 1 Inpatient 2 Inpatient 3 DOA 100-pitel 1 Inpatient 2 Inpatient 3 DOA 100-pitel 1 Inpatient 3 DOA 1 Inpatient		Residence 6 V Other	r: Scene		
on O mading ath. r: Aft	Ë	1 Natural 5 Pending (Month, Day, Year) 255. Time of Figure 255. Highly at Work?	204, 2000112011	on injury occurred			

Division of To the Hospital or Attending within 24 hours after death. To the Funeral Director: Af completely filled in by the fun

31. Date filed (Month, Day, Year) NOV 1 2 2009 State Registrar

Medical Certificatio

2

3

4

Accident

Suicide

Homicide 29a. Certifier 1 (Check only one) 2

29b. Signature and title of certifie

Victor Weedn MD JD

Investigation

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

28f. Location (Street and Number or Rural Route Number, City

November 6, 2009

29d. Date signed (Month, Day, Year)

or Town, State)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November Fannie Ellen Honsberger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner sight Medical Anne unni Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 31, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1 □ M 2 🖵 F Maryland 212-46-3044 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hygiene. Internet of Health and Mertal Hygiene in Internet of Health and Mertal Hygiene in Internet it item 72 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Product Extr. direct must be a collision of the product in the Internet in 1 Yes 2 No MD Dundalk Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21222 1958 Guy Way Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Hander Tonuc Baltimore, Maryland 21215-0036 1 □Yes 2 및 No Specify: ò 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Factory 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola May Ireland Charles William Rutherford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1958 Guy Way Dundalk, Maryland 21222 Marvanne Honsberger 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 6, 2009 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-transit Exami and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical Hospital or Attending Physician: The law requires that the death certificate 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 Dano 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2/ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 36251 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1:53P M 2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Social Security Numbe Date of Birth (Month, Day. **Funeral** Days Min. -38-381 Months Hours 1 M M 2 □ F 3 Director 19 Usual Residence of Decedent the Maryland 10b. County State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show addeal Examiner must be notified at 1 Yes 2 No Completed by Funeral Director mo 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygene. and 10 ment of Health and Mental Hygene. and It file m 27 is marked other than "natural;" or items 23a or : ury or other traumatic event, the Medical Exercities must be on ury or other traumatic event, the Medical Exercities must be on the property of the Medical Exercities. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 ☐ Divorced lac 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ ason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31792 Key Thomasville -Wei GA BIMUM 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Peace of Cen. 114/09 4 ☐ Donation 5 ☐ Other (Specify) Rest Thomasville, GA. 21. Signature o Funeral Service Licensee 22. Name and Address of Facility 222 TW. NOTH 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical netastasto prostate Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Day to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical his certificate has been signed by the attending p director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

Medical

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

within 2.

29c. License number

29d. Date signed (Month, Day, Year)

20001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36252 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Robert William Hesse 15:42 PM 08 11 12009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore VA medical MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-29-1933 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Min. 220-30-2706 76 MARYLAND Director Usual Residence of Decedent 10a. State MD 10c. City, Town or Location 10d. Inside City Limits 10b. Cou or 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "housal Examinating rough by nothing a BALTIMORE MIDDLE RIVER 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1931 WILSON POINT ROAD 21220 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after Affiled Folices: 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 □Xo Specify WHITE þ Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUILDER CONSTRUCTION 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental F. should be RAPHAEL HESSE **ESTELLA** (WALTER) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar em 27 ls 1931 WILSON POINT ROAD JANET POPE/DAUGHTER BALTIMORE, MD 21220 Department of Heal Important: If Item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11-10-09 CATONSVILLE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee ROSEDALE, MD 1211 CHESACO AVE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician years Chronic lymphoid lukemio disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner - cell lynghomo Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached Ö the 9 Unknown 9 Unknown signed by the 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred I or Attending Fafter death. After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier P24343 M.D. person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

10 N

Zendell

31. Date filed (Month, Day, Year,

M.D.

32. Registrar's Si

greene St.

Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month November 07, 2009 10:15 P.M Mary Catherine Heidecker Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Walkersville Glade Valley Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Country) MD Social Security Number Feb. 11, Year 922 Funeral 1 □ M 2 🛚 F Min. Months Days Hours 214-14-3614 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location br than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State Director 1 🗆 Yes 2 🖾 No Frederick Frederick MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21702 by Funeral 100 Burgess Hill Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No White 1 Never Married 2 Married Specify: 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) Mary Catherine Knight မ John Patrick Hoban 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8864 Briarcliff Lane; Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) Georgeann Fiedler Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 11/11/2009 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. LICH Signature of Funeral Service 1630 Edmondson Avenue; Catonsville, MO1537 Pm 1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as -- onsequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Vear 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28d. Describe how injury occurred 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 27 Manner of Death Certificate: Hospital or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No after death. Director: Aft Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide completed filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a

To the Funeral Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 050603

State Registrar Thryw

31. Date filed (Month, Day, Year)

anex

ar's Signature

Frederick,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State Registrar	Cer	tificate of Death	Reg.	No. 2009	3 t
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time
	Physic Med		Margaret M. Howar	th		November	r ^{Day} 8,20009	7:5
4	Exam		4a. Facility Name (if not institution, give street and number) Stella Maris Hospice		4b. City, Town, or Location of De Timonium	ath	4c. County of Death Baltimor	re
	Funera Directo		218-22-1208 1 D M 2 T F	e (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		927 Penn	olace (Stat
	d Iow	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		1	Od. Inside
	Marylan 28a-f sh otified a	Director	Md. Baltimore	Ess				1 🗆 '
	s 23a or 3	Funeral D	7 Beefwood Court		10f. Zip Code 21221	10g.	. Citizen of What Coun	itry?
.58 a.m. 15-0036	s filed within 72 hours after death with the Maryland tal Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	≦	11. Marital Status 1 □ Never Married 2 □ Married 3X Widowed 4 □ Divorced 12. Was Decedent 8 Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates.	No	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pud I ☐ Yes 2 M No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, e Specify: Whj	etc.
7:58 a. 215-0036	n 72 hours a t. an "natura Medical Es	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give	dent's Usual Occupation kind of work done during most of w O NOT use retired)	vorking 16b	b. Kind of Business Ind	dustry
7	within /giene.		6th	Sol		Ma	artins	
2009 Vland (should be filed wir and Mental Hygie is marked other aumatic event, th	To Be	17. Father's Name (First, Middle, Last)	(unk)	18. Mother's N	Name (First, Middle, Maid La	len Surname) (l	unk)
∞ <u>=</u>	should and N is me		19a. Informant's Name/Relationship (Type, Print Daug		ng Address (Street and Number or	-		
E E	nd 2 seleth m 27 her tr		Darlene A. Howarth		efwood Court			
NOVEMBER 8, 200 Baltimore, Maryland	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crer Meadowr	natory or other place) NO	vember	c. Location - City or To lkridge.	
NO Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	/	2. Name and Address of Facility K			1 Ho Md.2
Į	Priysiciar Medica Examine	al	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as		er the mode of dying, such as card	ac or respiratory arrest,		Approxir Interval E Onset ar
ħ.		Examiner	cause. Enter Underlying Lause (Disease or Injury that initiated events C	a consequence of):				
.TH 68760	ate be e physicia the buri	/Medical	d	-				
HOWARTH O. Box 687		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day
RET B	ires that th signed by d be detac	2	Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
MARGARET HOWAR Records, P.O. Box	The law requ ate has been page 2 shoul	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 X	24b. Were autoprior to condeath?	mpletion
	cian: ertific ector,	Be (25. Was case referred to medical examiner?		26. Place of Death (C	heck only one)		
of Vi	ng Physia fter this couneral dire	은	1 ☐ Yes 2X No 1 ☐ Inpati 27. Manner of Death 1X Natural 5 ☐ Pending (Month, Da		f 28c. Injury at work?	g Home 5 Residence 28d. Describe how in		<u>_HOSI</u>
Division of Vital	l or Attendi after death Director: A	Certificate:	2 Accident 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injudding, et	ury - At home, farm, str c. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural tate)	l Route Nu
Á	ne Hospita n 24 hours ne Funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of each of the control of the certifying Nurse Practioner To the	examination and/or inves	tigation in my opinion death occurr	ed at the time, date and pl	lace, and due to the cau	use(s) and
	To the within To the comp		29b. Signature and title of certifier		29c. License number		Date signed (Month, I	
			30. Name and address of person who completed cause of o	death (Item 23a) (Type, I	Print)			

ryland21221 n - City or Town, State dge, Maryland neral Home, PA re, Md.21222 Approximate Interval Between Onset and Death Date of delivery Month Year Day ontribute to the cause of death? 3 Probably 4 Unknown b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other (Specify) HOSPICE urred mber or Rural Route Number, nner as stated. due to the cause(s) and manner stated. manner es statue ned (Month, Day, Year) TIMONIUM, MD 21093

36254

7:58 А.м

9. Birthplace (State or Foreign Pennsylvania

10d. Inside City Limits 1 ☐ Yes 2X No

Registrar DHMH 17 Rev 7/2009

State

JACKIE JONES, CRNP

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 10:10 AM Cecelia Jennings 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimae University Baltimore OF Maryland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√2 F 218-18-3774 84 1/4/25 **Director** MD Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 23a or 28a-f show event, the Michael Exat, i.mr. rust be notified at 1X Yes 2 No MD N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 Charraway 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 'natural", or items 11. Marital Status 72 hours after African Specify: 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify þ 3 Widowed 4 Divorced Ämerican Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Self Catering 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Hughes Mary Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Johnson/Daughter Charraway Balt.,MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/14/09 Hanover, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}Hari P. Close F. Svs, P A 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to for as a consequence of): Intarction disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Diabetes 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertensia 24a. Was an has autopsy certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No ours after death.
neral Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 1043 44 5976

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11 per Fb G897 11/12/09 TT
State of Maryland / Department of Health and Mental Hygiene 2009 36256 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** 0 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Had 8. Date of Birth (Month, Day, 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2 M 219-30-2802 MAY 4, Director 00 1909 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantian mant he maintened. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1954 W. FAYETTE STREET USA 21223 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marita Status ±d 2 ☐ Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify: 3 Widowed 4 □ Divorced Slac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 COOK BALTIMORE CITY SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSHUA SMITH FANNIE SAMPLE ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY MOORE/DAUGHTER 1954 W. FAYETTE ST. BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 11-16-09 BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee orl 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** /Medical Due to (or as a consequence of): **Examiner** ERIPHERAL VAS OUL AIL DISEASE Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ATTENDIN 4 NOV 200 9 00056948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Just 3H PUTE TANVIVDA 300 ARMORT 3 ALTIMENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 36257 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:50 PM obect Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital <u>Takoma Park</u> <u>Montgomery</u> 8. Date of Birth (Month, Day, Year) Feb 20, 1917 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 🕅 M 2 🗆 F Months Hours South Dakota 92 Director 213-38-0881 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Prince George's 1 Yes 2 No Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4409 East West Highway 20737 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give ð 1 ☐ Never Married 2 🏋 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Completed 41-46 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest t grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) biochemist research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edwin Anthony Johnson Katherine Bacon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6212 Seminole Place College Park, MD Judith Johnson/spouse 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Star 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Signature conneral Sove Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Thysician disease or itio Wat Medical Due to (or as a consequence of): Examine DEUMONI Ecquentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed **Director:** After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director. g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗌 No 욘 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License number

29d. Date signed (Month, Day, Year)

50

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

			1 - State Registrar	,, ,, ,, ,	Cei	rtificate of	Death		Reg. No.	2009	36258
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month	Day	Year	3. Time of Death
· Ang	/Medic		100ev 1	Jones		4h City Toyun a	or Location of Death	11	06	2009 County of Death	10.32
	Examin	er	4a. Facility Name (If not institution, give Sinai Hospital		~ 0	, ,	altimore			N/A	1
	Funeral	_	5. Social Security Number 6. S			If Under 1 Year	If Under 24 Hrs.				place (State or Foreign
и	Director		213-54-4344	^{R M 2□ F} 60	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 1 0 / 0 2 /	194	9 Mar	yland
	pu »		Usual Residence of Decedent 10a. State 10b. County	100 0	h. Tours or Lo	antina					10d. Inside City Limits
	aryla shov	ក	,		ty, Town or Lo						1 ☐ Yes 2 ☐ No
	the M	Director	MD N	/A		Balt:	Lmore		10a Citis	zen of What Cou	A
	with with be r		3816 Bartwood	Poad		21215	=		U.S.		and y:
	ms 2%	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13.1		J Hispanic Origin? (Sp an, Mexican, Puerto			4. Race - Amer	
9	or ite		1 ☐ Never Married 2√2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No	1			Rican, etc.)		Black, White	, etc.
303	ral",	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1∐Yes 2 X ∏No	ъресну:		,	Specify: BL	ACK
5-(172 hours after death with the Maryian "natural", or items 23a or 28a-f show obleat Exhmirer must be riciffied at	lete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Kin	nd of Business/I	ndustry
12	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, if we fledical Examirer must be rediffed at	Completed	Flementary/Secondary (0-12) 12th Grade	College (1-4or 5+)		sing Ins			Balt	imore	City
9	filed Hygi ther		17. Father's Name (First, Middle, Last)			,	18. Mother's Name	e (First, Middle,	. Maiden S	Su <i>rn</i> a <i>m</i> e)	
lan	thould be on the marked of marked or	To Be	John	Mac	:k		Josephi	ine	J	Tones	
ary	2 shou and N is mai	_	19a. Informant's Name/Relationship (7	Type. Print)	1	,	and Number or Rur				
Σ	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	1	Belinda D. Jones	s (wife)	3816	Bartwo	od Rd.,	Balti			land 2121
ore	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Bomoval from State	cemetery, cren	sition (Name of natory or other pla	ce)	Date		cation - City or T	
Ë	Pages tment of tant: If its jury or o		4 □ Donation 5 □ Other (Specify			m. Park					, Maryland
Baltimore, Maryland 21215-0036	permit. Pago Department Important: I any injury o once.		21. Signature of Funeral Service Licen	h N. Wille	100 2 2 3 2 2 3 2 2 3 2 2 3 2 2 2 2 2 2 2	Name and Address of Ad	ess of Facility I Brown Fulton	Jr. F	uner Balt	al Hon	ne 21217
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deat							Approximate Interval Between
Same.	Physician		Immediate Cause (Final disease or condition	. 4	rina	nes gh	ent de	slag		10	Onset and Death
,	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
	LAdillilei	_	Sequentially list conditions,	b							
	ted nsit	nine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	neuce ori:						
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c	uence of):						
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68	tificat g phy as th	Medical							-		
Вох	eath cer attendir for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		∃ Ectopic pregnano	27		2	3d. Date of deli	
В	The law requires that the death ce ate has been signed by the attendi page 2 should be detached for use	Physician/	in the past 12 months? 1 ☐Yes 2 ☐No	4 ☐ Pregnant at time of o		Other (specify)	y			Month	Day Year
P.O.	at the d by t etach	Phy	9 ☐ Unknown Part II. Other significant conditions €		ulting in the co		on in Doubl	220 Did t	obacca us	no contributo to	the cause of death?
ds,	uires tha signed d be det	ρ	Part II. Other significant conditions	a close (186	2 21	Land	enin ranti.			ose communicate to	
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æ	ne law e has ge 2 s	μ		Stopuje	acs			24a. Was autoperfo		prior to c death?	topsy findings available completion of cause of
<u>a</u>	in: The		25. Was case referred to medical				00 B) (B)	1 □ Yes	2 N o		2 No
5	Physician: r this certificaral director, p	o Be	examiner?	Hospital:	ER/Outpatier	ot 3 🗆 DOA Oth	26. Place of Deather: 4 ☐ Nursing Ho			□Othor (Case	N(5.1)
0	g Phy erthi	ü	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe			ary)
<u>.</u>	Attending or death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation		Injury		k? Yes 2 □No				
Division of Vital Records,	I or Attenc after death Director: I in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Street and wn, State)	d Number or Ru	ral Route Number,
	oital o urs af eral Di										
i"	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, deati	h occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	date and	and manner as place, and due	to the cause(s)
	To the within 2 To the comple	2	29b. Signature and title of certifler	A		29c. Licens				e signed (Month	-
			149	rup)		1)	لم عدا م			118/09	
			30. Name and address of person wing o	completed cause of death (Item	n 23a) (Type,	Print) 1834	Creen	U 1	110.	RI	21208
	Sta Registr		31. Date filed (Month, Day, Year)	2009 32. Registrar's Signa	iture A.	parked				19	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of He rtificate of E			ene 2009	36259			
	Physici		1. Decedent's Name (First, Middle, La	C.	Tones			2. Date of Death Month	Day Year 5 2009	3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town, or I	Location of Death		4c. County of Death				
	Funeral		Tate Hospice Ho 5. Social Security Number 6. 8	Sex 7. Aq	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 01/18/1		aplace (State or Foreign intry)			
	Director		408 14 4969 Usual Residence of Decedent	1□ M 2154	88 Yrs.	mentio Bayo	110010	01/18/1	.921 Tei	nnessee			
	show	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	the Mi	Director	Maryland Anne	Arundel	Glen B	10f. Zip Code		100	. Citizen of What Cou				
	23a or		5808 Ritchie S	treet		21	061		U.S.A.				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygliene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No l	Was Decedent of His If Yes, specify Cubar 1 □Yes 2 🛂 No		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: W				
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e,	l and 2 Health em 27 I	-	Deborah Danfort	h / Daught		Ritchie			nie, Mary]				
mor	Pages tent of I nt: If Ite ry or of	ĺ	20a. Method of Disposition 1			esition (Name of matory or other place	1 11 /0						
Baltimore, Maryland 21215-0036	permit. Departm Importa any Inju			Glen Haven Mem. Park 11/09/2009 Glen Burnie, Maryl 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21									
	_		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent					Approximate Interval Between			
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a/	Renal.	Cancer	<u></u>			Onset and Death			
	Examiner			Due to (or as	a consequence of):								
,	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
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Box	Attending Physician: The law requires that the death certific robath. rotath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>			23d. Date of deli	very Day Year			
s, P.O	s that ti med by e detac	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?			
ords	w requires been sign should be	ted b						1 □ Yes	2 No 3 Pro	obably 4 nknown			
l Rec	rsician: The law s certificate has b irector, page 2 st	Completed						24a. Was an autopsy performe	prior to o death?	opsy findings available ompletion of cause of 2 □ No			
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death	(Check only one)		He we do			
Division of Vital Records,	Attending Phys death. ctor: After this y the funeral dir	Certification: To	1 Yes 2 No 27. Manner of Death ↑ Datural 5 Pending 2 Accident investigatio	28a. Date of Inju	ent 2 ER/Outpatier ry 28b. Time o lnjury	f 28c. Injury	4 LI Nursing Hor	ne 5 Residenc		ity)[705](1900)			
Divis	al or Attend s after death I Director: , ed in by the f	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc.	ury - At home, farm, str c. (Specify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,			
1	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)	hysiclan: To the best miner: On the basis o and manner sta	of my knowledge, deat f examination and/or in ated.	h occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the cau ed at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)			
り	To th To th	Me	29b. Signature and title of certifier	4. Ki.s	son, mil	29c. License	number ULF 3 R	29d	I. Date signed (Month	, Day, Year)			
		-	30. Name and address of person who	completed cause of d	eath (Item 231) (Type,	Print)	2140	/	13/0/				
	Sta	te	31. Date filed (Month, Day, Year)	82. Registr	ar's Signature	as one	0170	/					
	Registr	ar	MAN TS SOO	J Senia	10. 149 COL	G							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 36260 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 200^{Year} PM November 9:49 Grace W. Josey Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5550 Tuckerman Lane #356 Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 😿 F Months Days Hours Min. July 28, 1917 040-07-2044 92 Yrs Connecticut Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10a. State **Funeral Director** 1 ☐ Yes 2X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 5550 Tuckerman Lane #356 20852 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc ō þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Laboratory Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be file rtment of Health and Mental rtant: If item 27 is marked on njury or other traumatic ew n and Mental မ Joseph W. Wallace Einera Hansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Josey/Son 4410 Franklin Street, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Milfordside Cementery Nov. 14, 2009 Woodbridge, Connecticut 21. Signature of Funeral Service Licensee

HOUR, Nawhon Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01530 7557 Wisconsin Avenue Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Lung Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): Arthritis that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Hypertension Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗶 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred the Funeral Director: After rpleted filled in by the funer injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

on wh

3200

30. Name and address of personal Ajay Reddy, 32

31. Date filed (Month, Day, Year)

D53691

Tower Oaks Blvd. #110, Rockville, Maryland 20852

November 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiones and All Copies Are Legible.

			For State Of Maryland / State Registrar	Cer	riment of Health and tificate of Death		Reg. No.	09	36261
	Dhyaisi		1. Decedent's Name (First, Middle, Last)			2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic	al	Jennie Janney				per 5,	2009	2:02 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	eath	4c. Cour	nty of Death	£ J
		3,54	3562 Mill Green Road 5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	Street If Under 1 Year If Under 24 F	Irs. 8. Date of Bir	th		arford lace (State or Foreign
ď.	Funeral Director		213-16-1201 1□ M 2⊠F 87 Usual Residence of Decedent	Yrs.	Months Days Hours M	Feb.7,		Coun	vland
	vland ow at		10a. State 10b. County 10c. City, T	own or Loc	eation	<u> </u>		1	0d. Inside City Limits
	Mary Frsh fied	ţo	MD Harford	St	reet				1 ∐Yes 2 TagNo
	h the	irec	10e. Street and Number		10f. Zip Code		10g. Citizen o	of What Cour	ntry?
	th wit 23a o 1st be	Funeral Director	3562 Mill Green Road		21154		US	Α	
	ems er mu	ne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pe	(Specify Yes or No uerto Rican, etc.))- 14. Ř	lace - Americ lack, White,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒No If Yes, Give Year or Dates:	1	☐ Yes 2 No Specify:		Spec	cify: V	White
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2	illed Hygi ther nt, t		17. Father's Name (First, Middle, Last)	поп		Name (First, Middle			
an	Mental Merked of atic eve	To Be	Benny Jachimski		Anna T	okarzowna	a		
ary		F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street and Number of	Rural Route Numb	er, City or Tow	vn, State, Zip	Code)
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e,	es 1 a of Heg		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Plac	e of Disponetery, cren	sition (Name of natory or other place)	Date	20c. Location	n - City or To	own, State
Ē	Pages nent of ant: If its ury or o		4 □ Donation 5 □ Other (Specify) Lake		Mem. Park 11/				
Baltimore,	permit. Pages Department of Important: If i any Injury or once,		21. Signature of Funeral Service Licens 19	Fu 1 6	Name and Address of Facilit S t Ineral Home of C 30 Edmondson Av	erling Ag Catonsvil Venue: Cat	shton S Le, Inc tonsvil	le. MI	Witzke) 21228
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or Vital Records,	w requires that the death cer been signed by the attendin should be detached for use	ed by				_ 1 🗆	Yes 2□No	3 ☐ Prot	oably 4 Dunknown
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Division	or Attending after death. Director: After in by the funer	fical	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home	e, farm, str		28f. Location	(Street and Nu	mber or Rura	al Route Number,
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	Hos Funda Sely	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle and manner stated.						
	To the within 2 To the complete	ž	29b. Signature and title of certifier		29c. License number		29d. Date sig		0
			PX (5W/5/m N)		14041		11	50	9
			30. Name and address of person who completed cause of death (Item 2:	3a) (Type,	Print) Me MD6	(Mr)	210	78'	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signatur NOV 1 2 2009	e	hall				

State of Maryland / Department of Health and Mental Hygiene 36262 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** рΜ LEONARD A. KRONSTADT OCT 31, 2009 930 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SUBURBAN HOSPITAL **BETHESDA** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funera! Months Days Hours Min 1 XXM 2□ F 25, 579.14.7040 85 ΝOV. 1923 **Director** NEWARK, NEW JERSEY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Evan ingra, ust be notified at 1 ☐ Yes 2√√No Director MD MONTGOMERY BETHESDA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 USA 4925 BATTERY LANE # 701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: WHITE δ er than "natural", 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **BUYER** RETAIL 12 7 Is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental ဥ ESTHER LIAPIN NATHAN KRONSTADT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SON 10201 GROSVENOR PLACE, BETHESDA, MD 20852 27 ALLEN KRONSTADT Department of Health Important: If item 27 any injury or other to once. timore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 BAYVIEW CREMATORY INC. NOV. 3, 2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) FINK FUNERAL HOME, P.A. du of Funeral Service GREGORY 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 Κ. FINK 1. Enter the disease k, or heart failure Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and one cause on each line. Immediat Cause (Final disease or undition resulting in a ath) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner use as the burial-trar Due to (or as a consequence of): physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ZPINO 1 □ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To o the Hospital or Attending Physical in 124 hours after death.

o the Funeral Director: After this completely filled in by the funeral di this ö 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2. and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 KA 31. Date filed (Month, Day, Registrar's Signatu State Registrar

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State of Maryland / Department of Health and Mental Hygiene? 36263 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:58 PM Month Year 09 **Physician** 10anne 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** 2 Days 1 □ M 2 🔀 184-20-6223 Director June 18, 1927 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director MD 1 ☐ Yes 2√☐ No Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 228 Edgewater Drive 21037 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: <u>Ş</u> Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, It a Manamatic context. Elementary/Secondary (0-12) College (1-4or 5+) school teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Ross Klein Jeanne Marie Walls ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Arundel Medical Center 2001 Medical Parkway Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of the eral Service wade, State and Address of Facility Board 655 W. Baltimore Street irector Baltimore, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Can e (Final disease or con him resulting in death) Physician nonths /Medical Due to (or al. a consequence of): Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence on The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as nse IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year n signed by the a Id be detached for 5 ☐ Other (specify) P.O. 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 2 🗆 No or Attending Physician: After this certific funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation hours after death. 2 Accident 1 ☐ Yes 2 ☐ No I Director: , 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled filled the Hospital 29a. Certifier 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year) Mame and address of vho completed cause of death (Item 23a) (Type, Print

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O. O. O.

Security Control Colors Security Colors Se			•	1 - For State Registrar		Olato C		ar y rain	Ce	rtificate of		Wie inai i iy	Reg. No.	2009	36264
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Control Cont		_										NOV.	_/_	2009	
Solicida Security Number Control Topic		Examin	er					101	U.,	4b. City, Town, o	or Location of Dear	th	4c.	County of Death	•
Director 10 20 20 20 20 20 20 20	4 **	Former				Sex MEDIC		e (In vrs. la	ast birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	rth	9. Birth	place (State or Foreign
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Ronald J. Kvech, Sr. Husband 13327 Peachtree Road; Ocean City, MD 21842 200 Method of Deposition	ary	shou and M s mar	-	19a. Informant's Name/Relation	onship (Type. Print)			19b. Maili	ng Address (Street	i and Number or Fi	ural Route Numb	er, City o	r Town, State, Zi	p Code)
Physician Medical Examiner Ph	Σ.	and 2 ealth a n 27 is		Ronald J. Kve	ch,	Sr. H	usba	and	1332	7 Peachtr	ee Road;	Ocean (City,	MD 218	42
Physician Medical Examiner Ph	o e	jes 1 r of H if iten		'	n 3 🗆	Removal from	State						20¢. Lo	cation - City or To	own, State
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Physician / Medical Examiner Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23a, Part 1. Enter the disease	or com	rications that	caused	the death	Do not en	630 Edmon	idson Ave	nue; Cat	tonsv errest	ille, M	
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1 Yes 2 No 3 Probably 45 Unknown	Ţ.	s that ned by deta		Part II. Other significant cond	itions	contributing to c	death bu	ut not resu	lting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
24a. Was an autopsy performed? 1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Yes 2 No 27. Manner of Death 1 Yes 2 No 28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28a. Date of Injury 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 4 Norwing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 4 Norwing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28c. Place of Injury 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Place of Injury 28c. Injury at Work? 28c. Injury at Work? 28c. Place of Injury 28c. Injury at Work? 28c. Place of Injury 28c. Injury at Work? 28c. Injury at Work? 28c. Place of Injury 28c. Injury at Work? 28c. Injury a	2	quires en sig uld be	q pa	11406	ER	TEN	د بخ					1 🗆	Yes 2[□ No 3□ Pro	bably 4 Unknown
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The state of the s	5	ng Ph fter th neral	Ë		dina	28a, Date	of Iniu	rv	28b. Time o						7/
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	5	lor At after d Direct J in by	ertifi	- date		28e. Place	e of Inju ling, etc	ary - At hou c. (Specify	me, farm, sti	reet, factory, office					al Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RENE DESMARAIS M.D. (100 E. CARROLL St. Salis bury M.D. 2180 I State Registrar NOV 1 2 2009		Hospita 24 hours Funeral stely fille		(Check only 2) Modic	al Ever	minar. On the	hacie of	fovaminat	tion and/or ir	wastigation in my	oninion dooth ood	urrad at the time	data and	I place and due t	to the equec(c)
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State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 2 2009	7			30. Name and address of pers RENE DESMA	on who	completed cau	se of de	eath (Item	23a) (Type,	Print) WU Sit	SALIS	bure M	10	2180	/
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09-08709	
Marilyn Kearney	

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aniyn Keamey		State of Marylan 1- For State Registrar		nt of Health and Ment te o <i>f Death</i>		g. No. 200	9 3626
Physicia ledical Exami	ın/	Decedent's Name (First, Middle,Last)			2. Date of Death Month November	n	3. Time of Death 1140 hrs
Colcai Exami	ici	Marilyn Fay Kearney 4a. Facility Name (if not institution, give street and numbers)	er)	4b. City, Town, or Location o		4c. County of Death	
		Maryland General Hospital		Baltimore		n/a	
Funeral Director		5. Social Security Number 6. Sex 7. 217–88–2481 1 M 2XF	Age (In yrs. last birtho	yrs. If Under 1 Year If Under	7 24Hrs. 8. Date of Birt Min. 04/08	Foreig	thplace (State or In untry) VA
/ any		10a. State 10b. County	10c. City, Town or				10d. Inside City Limits
Maryland 28a-f show d at once.	힏	NC Forsyth	Winsto	n-Salem			1 X Yes 2 No
th the Mary 23a or 28a notified at	Il Director	10e. Street and Number 2644 Crosland Hill Drive		10f. Zip Code 27106		g. Citizen of What Cour	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teatth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	/ Funeral	11. Marital Status 1 Never Married 2 Married Armed Force 1 Yes 3 Widowed 4 Divorced If Yes, Give Yeer	es? 2 No	 Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, Yes 2X No specify: 		14. Race - Ameri White, etc.	can Indian, Black,
ours af	d by	15. Decedent's Education (Specify only highest grade	completed) 16a. De	ecedent's Usual Occupation (Give king most of working life, DO NOT	ind of work done	16b. Kind of Business/I	
36 in 72 h han "n lical E	pleted	Elementary/Secondary (0-12) College (1-4	or 5+)	ensed Practical	,	Medical	
5-00; ed with sygiene other t	Compl	17. Father's Name (First, Middle, Last)	1110		s Name (First, Middle, M	- 1	
21215-0036 old be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Vernon Lee Spratley Sr			ces Saunder		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	2	19a. Informant's Name/Relationship (Type, Print) Maurice Kearney/Husband	26	Mailing Address (Street and Num 44 Crosland Hill	Dr Winston	n-Salem NC	27106
Baltimore, MD permit. Pages 1 and 2 sh Department of Health an Important: If item 27 injury or other trauma		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from	State cremator	Disposition (Name of cemetery, y or other place)	Date	20c. Location - City or	J
Itim nit. Pag artment ortant:		4 Donation 5 Other Specify: 21 Signature of Fundral Service Licensee	Baltim	ore Crematory 22. Name and Address of Facility	11.14.09	Baltimore,	
Balti permit. Departm Importa injury o		And The		22. Name and Address of Facility John L. Williams 4517 Park Height	s Funeral D. s Ave Balt	irectors, P imore, MD 2	, A : 121 5
Physician /Medical		23a. Fart I. Enter the disease, or complications that caus failure. List only one cause on each line.	sed the death. Do not				Approximate Interval Between Onset and
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiac Due to (or as a co	arrythmia				Death
		Sequentially list conditions, b. Increase	ed cardiac	fibrosis			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	onsequence of):				
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30x 68760, death certificate be exe e attending physician a I for use as the burial -	Mec	IF FEMALE: 23c. If yes, out	come of pregnancy	PII,27,permE, g		23d. Date of deliver	•
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BO;	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			Loo Dide		
i, P.O.	ā	Part II. Other significant conditions contributing to d				bacco use contribute to	bably 4 Unknown
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tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?		26.Place of Death			
of Vit Physic er this	٩	1 Yes 2 No		patient 3 DOA Other 4 me of Injury 28c. Injury at Work		Residence 6 Othe	r:
on c ending ath. or: Aft	tion	1 X Natural 5 Pending (Month, D	ay,Year)	1 Yes 2		,,	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The law requires that the death. The Funeral Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transil.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	of Injury - At home, fam	n, street, factory, office building, et	c. 28f. Location (S or Town, S		ural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or inv				
L S F S	ž	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	
		Mlin Brasself, MV)	O.C.M.E.		November 10, 2	
		 Name and address of person who completed cause Melissa Brassell, MD Assistant Medi 	,	111 Penn Street, Baltimore	e, MD 21201		
St Regist	ate rar	31. Date filed (Month, Day, Year)	strar's Signature	are			
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OCME 2006		UUNIE	V.(I)	- · · · · ·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36266 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death October Physician/ , 2009 1715 King Patricia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Year) May 12, 1 Age (In yrs. last birthday, If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Hours 1956 Washington, DC 578-78-8762 53 Director May Usual Residence of Deceden fshow or 28a-f shov notified at Page 1 and 2 should ue filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 🗌 No Prince Georges MD Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 20782 2015 Woodreeve Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗆 Widowed 4 🗀 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Amtrack Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Livingston Elizabeth Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per it. Page 1 and 2 Derartment of Health Important: If item 27 any injury or other tr once. 2015 Woodreeve Rd., Hyattsville, MD 20782 Robert L. King Jr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 10/21/09 Beltsville,MD . Signature of Foneral Service Licensee 22. Name and Address of Facility AGEE/MCKINNON Funeral Services 3821 14th Street, NW, Wash., DC 20011 M00996 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (one), a consequenci Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or a To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a conse Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be read hours after death.
Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 5 Other (specify) Month Pregnant at time of death 9 Unknown ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ဂ္ 1 Yes 2 E M 1 Inpatient 2 ER/Outpatient 3 DOA . Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed, (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave, Takoma Park,

20912-6392

MD

Registrar

State

7600

@arroll

32. Regist/ar's Signature

Nasreem Kango, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR G897 11/12/09 TT
State of Maryland / Department of Health and Mental Hygiene 2009 36267 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death S. 6, JANE NOVEMBER 2009 KAHN 1:40 A 4a, Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death JSSFA ARDEN COURTS MONTGOMERY KENSINGTON 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Months Days Hours 1 □ M 2 K F 94 212-48-9489 04-09-1915 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 X No MD MONTGOMERY POTOMAC 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code |7916 IVYMOUNT TERRACE 20854 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, MOSE В. STROUSE **BLANCHE** LAUPHEIMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGOT K. PETTIJOHN/DAUGHTER 7916 IVYMOUNT TERRACE, POTOMAC, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PARK: 11-08-2009 | REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. Signature of Fu 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a Rant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COHONARY disease or condition resulting in death) Due to (or as a consequence of): AUHEINGU Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 🕶 No 2 □ No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASST LIVING 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760.

of Vital Records, P.O. Hospital or Attending

State Registrar

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Examine

Physician/Medical

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Completed

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Certification: To

Medical

29a. Certifier

(Check only one)

d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examired must be notified at

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur

Physician

/Medical

Examiner

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After

within 24 hours after deat To the Funeral Director: filled in by the

completely

funeral director,

attending physician

certificate be executed

filed within 72 hours after

altimore, Maryland 21215-0036

29b. Signature and title of certifier

29c. License number D-27660

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year) 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 ϕ oswami, MD 11125, Rockville Pike Suite 110, Rockville, MD 20852

Alpana

32. Registrar's Signature Server

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36268 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 8:00 AM Medical Dolores Kramer November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 19, 1931 Funeral 6. Sex 9. Birthplace (State or Foreign Davs Min. 1 □ M 2 🗓 F Months Hours Maryland Director 215-30-7799 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? Funeral 941 Martin Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 X Widowed 4 □ Divorced Year or Dates. White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Icenroad Carrie Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17331 <u>Deborah Schaffer</u> 30 Chestnut Hill Circle Hanover. Pennsvlvania Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hill Cemetery 11-11-2009 Baltimore Maryland 5 ture of Fun ral ervite 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner INFERTION equentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury SHCPT - GUT

Due to (or as a consequence of): SUNDROME burial-tran that initiated events resulting in death) Last Physician/Medical ARTHRITTS RHEUMATOID DECHOS igned by the attending phys be detached for use as the I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ATRIAL FIBRILLATION 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should PHIMONARY FIBRESIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence (**Other (Specify) 2 Ko 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Watural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) NOVEMBER 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMUTE, MD 21204 DANIEUS DOBERMAN, MD 6701 NEMARIES ST, 8417- 4105

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

070

32. Regis rar's Signature

State of Maryland / Department of Health and Mental Hygiene 2009

36269 Certificate of Death 1. Decedent's Name (First, Middle, Last) TOYCE 2. Date of Death 3. Time of Death LYON.S **Physician** 3:00 PM 08 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/12/1959 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 F 50 MD 213-80-9395 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Marcial Examples. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Halethorpe 1 ☐ Yes ¾ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2804 Ohio Ave. 21227 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Construction College (1-4or 5+) Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert William Terry Jeanne Ruth Kennedy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Hayen Jr. / Friend 2804 Ohio Ave., Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State W. Arundel Crematory 11/16/2009 Odenton, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA Mal E. 4023 Annapolis Road, Halethorpe, MD 21227 m01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RATORY FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 □ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 □ Yes 2 □ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV.,08, 2009 Name and a fress of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER ST, BALTIMORE, MD State

DHMH 17 Rev 1/2001

Registrar

09-08531 Joseph Lewis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 36270

	1- For State Registrar	Cert	tificate of Death	Re	eg. No.	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,L	Lewis		2. Date of Deat Month November	Day Year	3. Time of Death 1205 hrs
	4a. Facility Name (if not institution, s 817 St. Paul Street	give street and number)	4b. City, Town, or Location of Baltimore	Death	4c. County of Death	A
Funeral Director	u. V	Sex 7. Age (In yrs. la	St birthday) If Under 1 Year If Under 1 Year Months Days Hours	1	th(MM/DD/YYYY) 9. Birth Foreig Cou	
the Maryland a or 28a-f show any tified at once.	Usual Residence of Decedent 10a. State 10b. County Maryland N 10e. Street and Number	/A	Town or Location Baltimo		0g. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once-Tuneral Director		12. Was Decedent Ever in U.	S. 13. Was Decedent of Hispanic Original	in? (Snecify Yes or No	USF	can Indian, Black,
	3 Wildowed 4 Divorce	Armed Forces? 1 Yes 2 No ed If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, 1 Yes 2 No specify:	Puerto Rican, etc.)	White, etc. Spe <i>cify:</i> Bla	cK
36 in 72 hour han "natu fical Ex or	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give k during most of working life. DO NOT of Shock Clem	use retired)	16b. Kind of Business/I	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica		st)		s Name (First, Middle, M	Maiden Surname)	
MD 21215 nd 2 should be fil alth and Mental I- m 27 is marked aumatic event. To Be		(Type, Print)	19b. Mailing Address (Street and Number 19b. Mailing Address Vernan	ber of Rural Route Num Ave Bal	nber, City or Town, State Himore, Ma	Zip Code) 21
MOFE Pages lent of F ant: If i	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec	Removal from State	Place of Disposition (Name of cemetery, trematory or other place) The Crematory	Date 11 13 09	20c. Location - City or Catorsville	
Baltimo permit, Pag Department Important: injury or ot	21. Signature of Funeral Service Lic	Parker	22. Name and Address of Facility 3512 Frederic	Parker Fu KAre Ba	neral Home Himore, Ma	19.A. 21229
Physician /Medical Examiner	23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)			ardiac or respiratory arre	est, shock, or heart	proximate Interval Between Onset and Death
red nsit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a consequence of				
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760, icate be executed physician and the burial - transi	X UNPENDED	X AMENDED 25a, 27, 113 Per FH G89 23c. If yes, outcome of pregi	7 11/13/09 JH		23d. Date of delivery	,
	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de wn 9 Unknown	_	pregnancy	Month [Day Year
P.O. E es that the iigned by the be detached	Part II. Other significant condition	s contributing to death but not re	esulting in the underlying cause given in Par	rt I. 23e. Did to	obacco use contribute to	the cause of death? pably 4 Unknown
Division of Vital Records, P.O. Box 683 tall or Attending Physician: The law requires that the death certifiers after death. In Director: After this certificate has been signed by the attending ted in by the funeral director, page 2 should be detached for use as I ertification: To Be Completed by Physician		· · · · · · · · · · · · · · · · · · ·	4	24a. Was autop perfor 1 🗸 Yes	esy prior to o rmed? death?	topsy findings available completion of cause of es 2 No
ital Fician:	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	26.Place of Death (ER/Outpatient 3 DOA Other 4		Residence 6 ✔ Othe	: Scene
nn of V nding Phys th.: After thi e funeral di	27 Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury 28c. Injury at Work	? 28d. Describe	how injury occurred	
Division o spital or Attending nours after death. neral Director: After filled in by the function:	2 Accident Investig 3 Suicide 6 Could r	oot be 28e. Place of Injury - At ho	ome, farm, street, factory, office building, etc	c. 28f. Location (Sor Town, S	Street and Number or Rustate)	ral Route Number, City
Division To the Hospital or Attent within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification		sician: To the best of my knowled ner:On the basis of examination a	ge, death occurred at the time, date and pla nd/or investigation, in my opinion, death occ			
Med Garage	29b. Signature and title of certifier	and manner stated.	29c. License number O.C.M.E.		29d. Date signed (Mo	
	30. Name and address of person w		23a)	21201		
6:-4	Ana Rubio MD. Assis	tant Medical Examiner 3. Registrar's Signat	111 Penn Street, Baltimore, MD	21201		

ORIGINAL

OCME

State of Maryland / Department of Health and Mental Hygiene, 36271 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 08:56 AM Russell E. Lawhorn November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. ARMED Bathmore , MD N/A Hospital 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral Days 1 M 2 □ F 74 223 38 8669 Director 01/01/1935 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Baltimore Maryland 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 72 hours after death with 21225 U.S.A. 215 West 8th Avenue or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Was Deceden _ Armed Forces? 1 □Yes 2 XNo Black, White, etc 1 ☐ Yes 2 ☐X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: ģ 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Mechanic 9th s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Lee Lawhorn Louise Alberta Karr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 West 8th Avenue Baltimore, Maryland 21225 Helen L. Lawhorn / spouse Department of Heali Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/11/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical the as attending properties for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No Ö 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 15Chemio 1 ☐Yes 2 ☐ No 1 □Yes 2 Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this ō 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No I hours after death.

uneral Director;

ely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c_License number 29b. Signature and title of certifier November 8, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 21229 Rodetty mouris 31. Date filed (Month, Day, Year Caton 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 36272 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 1^{Month} 8/20^{Day} 9 Physician Ruby Elizabeth Lowman 5:23 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 💢 225-42-5834 74 10/16/1935 North Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10h. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be redified at 1 ☐ Yes 2 ☐ No Directo MD Baltimore Halethorpe 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2013 Putnam Avenue 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify þ White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Harris, Sr. Elizabeth D. Crickmore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll E. Cooke, Jr. / Son 2013 Putnam Road, Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Harris Family Ceme. 11/14/2009 | Pinetop, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed physician ar s the burial-tr Due to (or as a consequence of) Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s been si should i Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed certificate 2 🗆 No 1 ☐ Yes 2 K No the Hospital or Attending Physician: this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 44 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide nin 24 hours af the Funeral Di npletely filled in 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Sal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 12164 November 10 2009 arare 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21229

State Registrar

MBANDAM BASKA

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

3455

WILKENS AVE

			For State Registrar	State of Ma	aryland		artment o			/lental Hy	giene Reg. No.	2009	36	273
	Physicia		1. Decedent's Name (First, Middle, La Nancy Gee Lau	ast)						2. Date of De Month Novemb	ath	200 ^{Year}	3. Time of 4:00	
A	Medic Examin		4a. Facility Name (if not institution, giv	e street and number)	-		4b. City, Tov	vn, or Locatio	n of Death	THO V CIII D		ounty of Death	14.00	
			532 Palmspring I	rive			Gaithersburg					tgomery	•	
	Funeral Director		232-62-8630	Sex 7. Age 1 □ M 2 🛣 F	e (In yrs. Ia: 75	st birthday) Yrs.	If Under 1 \ Months D	rear If Und ays Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da August 4	th y, Year) 1934	9. Birthp Coun Chir	olace (State o try) 1 a	r Foreign
	nd how	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation					1	0d. Inside Ci	tv Limits
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	or 28	흅	10e. Street and Number	102)		CITCLE	10f. Zip Co	de			10g. Citize	n of What Cour	ntry?	
	with s 23a ust b	era	532 Palmspring Dr	rive			2087	8			Unite	d State	s	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Decedent E Armed Forces?		ŀ	Vas Decedent f Yes, specify	Cuban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	etc.	
Ö	ours a	sted	3 Widowed 4 Divorced	Year or Dates.					.,.				ian	_
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פו	filed v al Hyg d othe vent,	B	17. Father's Name (First, Middle, Last)					18. Mo	ther's Nam	e (First, Middle,	Maiden Sur	name)		
ylaı	ld be Menta arked atic e	ပ	James Gee					Ng	an Sh	ing				
	12 should be filed within 72 lith and Mental Hygiene. 27 is marked other than "r traumatic event, the Mec		19a. Informant's Name/Relationship (Roly Jan/Son	Type, Print)		1				al Route Numbe Bethes				
re,		1	20a. Method of Disposition		20b. Pl		sition (Name on natory or other	of		Date		tion - City or To		
Ē	Page nent or ant: If ant: If ant: If any or		1 🔀 Burial 2 □ Cremation 3 ☐ 4 □ Donation 5 □ Other (Spec				zen Cenet		Novemb 2009	er 14,	Silver	Spring,	Marvlan	d
Baltimore,	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service Licer	Flint	M015	48 Ro	bert A. 1 West Mc	ddress of Fac	Funer	al Home/R ue, Rockv	ockvi11	e. Inc.		
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each line	the death								Approximat Interval Bet	e ween
-	Physician/	١,	Immediate Cause (Final disease or condition	Ovarian		cer							Onset and I	
	Medical Examiner		resulting in death)	Due to (or as a										
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	CONSEQUE	ence off:								
	red nsit	틀	cause. Enter Underlying	Due to (or as t	a conseque	criod oi).								
	n and al-tra	Exa	that initiated events resulting in death) Last	C. Due to (or as a	a conseque	ence of):								
90	e be e ysicia e buri	dical Examiner		■ d										
9289	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Med	IF FEMALE:											
9 ×	h cert tendir ir use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth			Ectopic preg	nancy			230	d. Date of delive	•	, d
Box	e deat the at ned fo	ysici	1 Yes 2 X No	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (speci	fy)				Month	Day `	/ear
P.O.	rat the		Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the u	nderlying caus	se given in Pa	ırt I.	23e. Did to	obacco use	contribute to the	ne cause of d	eath?
S, F	requires that the de been signed by the s should be detached	d by								1 □	Yes 2 🛣	No 3 🗆 Prol	oably 4 🗆	Unknown
ord	requ been shout	lete								24a, Was	an 2	24b. Were auto	osy findings a	available
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E	sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medical					26. Place of D	eath (Chec	1 \(\sum \) Yes	2X No	1 \(\text{Yes}	2 🗆 No	
Vit.	nysici lis cer direc	10 B	examiner? 1 🔀 Yes 2 □ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	ER/Outpatien	t 3 🗆 DOA	Other: 4	Nursing Ho	ome 5 K Resid	dence 6 🗆	Other (Specify)	
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ion	tendii leath. lor: A the fu	ifice	2 Accident Investigation	he			M	1 Yes 2	□ No					
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	4 Homicide determined		iry - At hor :. (Specify)	ne, farm, stre	eet, factory, of	fice		28f. Location (S City or Tov		umber or Rural	Route Numb	er,
	spital nours neral filled		29a. Certifier 1 X Certifying Ph	ysician: To the best of	mv knowle	edge, death o	occured at the	time, date ar	nd place, ar	nd due to the ca	use(s) and n	nanner as state	d.	
	n 24 h	Medical	(Check 2 Medical Exam	niner: On the basis of ex rse Practioner: To the	xamination	and/or invest	igation, in my	opinion, death	occurred a	t the time, date a	and place, an	d due to the ca	use(s) and ma	nner stated.
	To the comp		29b. Signature and title of certifier	<i>b</i>		<u> </u>		cense numbe				igned (Month,		
					/ n	\cdots)	D35	635			Novem	ber 9,	2009	
1			30. Name and address of persor who									17		
			Joseph Kaplan, 1 31. Date filed (Month, Day, Year)	M.D. 9715 232. Registra			enter D	rive,	#221,	Rockvi	ille,	Marylar	nd 208	00
	Stat Registra		NOV 12 2009		a o oignatt	back								

DHMH 17 Rev 7/2009

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

Brian Carpenter,

Year)

31. Date filed (Month, Day,

29c. License number

9901 Medical Center Drive, Rockville, Maryland

D64502

29d. Date signed (Month. Day, Year)

November 5, 2009

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Amend #8 per FH G897 II/IZ/09 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 36275 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** NOVEMBER 9:10 PM LIKHTSHTEYN "5 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A SINAI MOSPITAL OF BALTIMORE ACTIMORE CITY 8. Date of Birth (Month, Day, Year) 07-27-192525 Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** 1 M 2 K Days Months Hours 218-45-9310 84 Director BYELORUSSIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛛 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1807 SNOW MEADOW LANE 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 2 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uth and Mental F Be LEV MELAMED SARA ပ **ITSENBERG** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health mportant: If item 27 KHANA STOLYAROVA/DAUGHTER 1807 SNOW MEADOW LANE, BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 11-08-2009 REISTERSTOWN, MD atyre of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. Moloce 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardiac or each line.

Immediate Cause (Final disease or condition a CELEBROVASCIVAR ACCIDENT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed that initiated events resulting in death) Last to (or as a consequence of). 68760. Physician/Medical The law requires that the death certificate the Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) P.O. Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 □Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAME 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav 3:10 P M NOV Kenneth Dale Litherland 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Silver Spring Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, APR 2, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director 312-26-8205 78 Indiana Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits Ħ s 1 and 2 should be filed within 72 hours after death with the Marn of Health and Mental Hygiene.

Item 27 Is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examinator must be notified. 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 United States 2501 Musgrove Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1XYes 2 □ No 195 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1955 Baltimore, Maryland 21215-0036 1 ☐Yes 2X No White \$ If Yes Give Specify: Specify: 3 Widowed 4 Divorced 1960 Year or Dates: 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Consulting Engineering 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Meeting Planner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elisha Jennigs Litherland Bessie Buchanan ည 19a. Informant's Name/Relationship (Type. Print)
Michael Litherland/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11215 Oak Leaf Dr. #1817 Silver Spring, MD 20901 permit. Pages 1 a
Department of He.
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 11/11/09 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service License 401555 # Appe and the spiration Services 20910 Robo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 s autopsy 1 □ Yes 2 🖸 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir ၉ 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred Division 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

RAMAN

31. Date filed (Month, Day, Year)

K

TERRY

3503

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MS

32. Redistrar's

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

the attending physician and hed for use as the burial-tran After this certificate has been signed by the ifuneral director, page 2 should be detached certificate After this within 24 hours after death To the Funeral Director: filled in by

Funeral

Director

28a-f show

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1 and 2 should be fill Health and Mental H tem 27 Is marked ott

Pages 1

permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

filed within 72 hours after

3altimore, Maryland 21215-0036

event, the Medical Examiner must be notified at

2 Completed Be Certification: To

Medical

State Registrar

5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D261

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AFIQ

31. Date filed (Month, Day

WA 14 FOREST

State of Maryland / Department of Health and Mental Hygiene 2009

1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11, 2009 5:20 A M November Helen Joyce Meehling /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Hebrew Home Greater Washington 8. Date of Birth (Month, Day, Year) 08/18/1926 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**X**□ F New York 84 096-20-2158 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examiner must be notified at 1 XYes 2 □ No Rockville MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20852 6121 Montrose Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White If Yes, Give Year or Dates Specify: <u>م</u> 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jewelry Jeweler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Brazner Emmanuel Kleinfeld 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2007 Belmont Road, NW, Washington, DC Robert Meehling/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Ardent Cremation Services | 11/10/2009 | Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee 21076 Laura C. Hardesty 7522 Connelley Drive, Ste.N, Hanover, MD M01197 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death A Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown nis certificate has been si director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t 1√Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #15,-20a & 22, per Fh g897 11/12/09 TT

State of Maryland Department of Health and Mental Hygiene 2009 36279 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day OISOM 29 Virginia Montgomery october 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice/Northwest Hospital Randallstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days Hours 86 Oct 13, 1923 239-38-3405 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1√ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5631 Midwood Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: black 3 ☐ Widowed 4 🌠 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk mik (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk John Simmons Ella Mae Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Torling Ct. Apt. F, Gwynn Oak, MD 21207
5401 Old Court Road Randallstown, MD 21133 19a. Informant's Name/Relationship (Type. Print)
Geraldine Constatine (Daughter)
Seasons Hospice 20b. Place of Disposition (Name of cemetery crematory or other pla Joseph Brown Fand Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State Name and Address of Facility Joseph H. Brown F.H. 2140 N. Fulton Ave.

1 11/06/09 Baltimore, MD

1 11/06/09 Baltimore, MD 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4□Donation 5⊞Oth r (Opecify) in state Signature of Funeral Service State Anatomy Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm i te Cause (Final Adenocarcinoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dud to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 1 No 1 ∐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ItOSPICE Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner requires that the death certificate be executed 68760, Ö ۵. Division of Vital Records,

Physician/Medical Examiner physician and s the burial-trans attending p been signed by the should be detached Completed by has page 2 Hospital or Attending Physician: The certificate director Be Medical Certification: To this After th funeral 124 hours after death.

• Funeral Director; A pletely filled in by the fu death. completely

Physician

Examiner

Funeral

Director

28a-f show

Director

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exymitment nust be notified at

Physician

/Medical

Saltimore, Maryland 21215-0036

/Medical

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies

29c. License number

OUD COUNT ROAD

29d. Date signed (Month, Day, Year)

RANDALLSTOWN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401

31. Date filed (Month, Day, Year) Begistrar's Signature

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State Registrar

To the I within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 State of Maryland Panaying the alth and Mental Hygiene 2009 36280 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year 2:38 AM November 2, Anna Florance Mills 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Golden Manor Assisted Living Baltimore 8. Date of Birth (Month, Day, Year) Aug 07, 19 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** Months Days 1 M 2 V F Hours Min. 92 217-07-9802 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showevent, the Medical Examinar must be notified at Director 1 ☐ Yes 2 XNo MD Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 697 Jacob Tome Hwy 21904 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress Service Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mentai George Meyer Josephine Unk traumatic 0 of Health and M 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted Mills /Son 697 Jacob Tome Hwy Port Deposit, MD 21904 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any Injury or out. Nov Beltsville, Maryland Chesapeake Crematory 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives . 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, attending physician requires that the death certificate be Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) the 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate Division of Vital 2 🗆 No 1 □Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Thesidence 6 Nother (Specify) Assisted 2 1 ☐ Yes 2.₩0 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 2 ☑ Accident Certification: 28b. Time of 28d. Describe how injury occurred Living After 28c. Injury at Hospital or Attending 5 Pending death. after death

Director; / investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the I 29b. Signatur and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) NOV 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ANKAT KHETERPAL 9106, PHILADEPHIA ROBD #208, BAYIMURE, ND 21237 32 Registrar's Signature

D0060560

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36281 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year MATRANGA ANGELO 11:12 AM Medical ovense 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS MEDICAL CENTE BALTIMORE BAYVIEW 5. Social Security Number 1 Year If Under 24 Hrs. **Funeral** 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Hours Oct 26, 1918 215-03-1930 91 Director Mary land Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h Count filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits ty⊡ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4114 Dudley Avenue 21213 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced 42-45 Specify: White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Coilege (1-4 or 5+) Elementary/Seconday (0-12) chef/cook food industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pete Matranga Rose DeStephano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie Matranga/spouse 4114 Dudley Avenue Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Sign at the of Emeral Sort S Wad State and Address of Facility acid board 655 W. Baltimore Street ector Baltimore, MD 21201 Pair 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Seuse (Final Onset and Death Physician, disease or condition resulting in death) oronary artery Medical Due to (or as a consequence of): Examiner pertens Sequentially list conditions, if any leading to immodistic cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant 9 Unknown Month Pregnant at time of death Day Year 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examina?
1 Yes 2 No Hospital: Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Natural ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 03 D0069223 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 4940 EASTERLY BALTIMORE MI

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cortificate of Death

2009 36282

		Registral	icate of Death	Reg. No.				
Physic Medical Exam		1. Decedent's Name (First, Middle, Last) Casandra Milk	er -	2. Date of Death Month Day	Month Day Year			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	November 6, 200	County of Death .			
		1718 McHenry Street	Baltimore		NA			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday) If Under 1 Year If Under 24Hr Months Days Hours Mi	_ ``	D/YYYY) 9. Birthplace (State or Foreign			
Director		1 M 2 F	Yrs. World's Days Hours Will	Tan. 30, 19	88 Country) Maryland			
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tox	wn or Location		10d. Inside City Limits			
A	_	Manyland N/A	Battimere		1 Yes 2 No			
ne Maryland or 28a-f show fied at once.	Director	10e. Sheet and Number	10f. Zip Code	10g. Citize	n of What Country?			
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frer de		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	S	pecify: Black			
2 hours aft "natural" I Examine	ed by	15. Decedent's Education (Specify only highest grade completed) 16.	Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re	work done 16b. Kirn	nd of Business/Industry			
36 in 72 l han ", lical F	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	Cashier		lendy's			
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Su	Jrname)			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matte event, the Medical Examiner must be notified at once	å	17. Father's Name (First, Middle, Last) Calvin Miller	Sandr		,			
ID 21 should and Me 7 is ma	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or 1502 N. Mount S					
		Teanette Huntley-mother 20a. Melrod of Disposition 20b. Plac	e of Disposition (Name of cemetery,	Date 20c. Lo	cation - City or Town State			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State crem	atory or other place) Zion Cemeter 111	1 1	Solowne Maryland			
Baltimo permit. Pag Department Important:		4 Donation 5 Other Specify: 21. Signature of Fun ry Service Licensee	22. Name and Address o Facility	Ko timeral	Ilan OA 21720			
W P P P F F F F F F F F F F F F F F F F		gernfarker	3512 Frederick A	ve Battin	ore Maryland			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.		or respiratory arrest, shock	Approximate Interval Between Onset and			
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		Sequentially list conditions, b						
	iner	if any, leading to immediate Due to (or as a consequence of):						
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760, cate be execut physician and	an/Medical	IF FEMALE: 23a, PII, 2	7,28a-f,permE, g898	2/17/09 TT	Date of delivery			
68760, ertificate bu	an/I	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn		onth Day Year			
O. Box 6 at the death cer I by the attendi	Physicia	1 Yes 2 No 9 V Unknown g Unknown	5 Other (Specify)					
P.O. Es that the greed by the detached		Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death?			
S, P.C	ed by	Cocaine use		1 Yes 2 🗸 1	No 3 Probably 4 Unknown			
cord law requals been 2 shout	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
Rec The la	틩			performed? 1 ✓ Yes 2 No	death? 1 ✓ Yes 2 No			
ital Reician: The scertificate rector, page	å	25. Was case referred to medical examiner? Hospital: 4 Inpution: 2 FBN	26.Place of Death (Check					
n of Vi ding Phys After this funeral di	유	1 Yes 2 No	Outpatient 3 DOA Other Mursi Do Time of Injury 28c. Injury at Work?	ng Home 5 Residenc	e 6 Other: Scene			
Sion of trending death.	ţį	Pending FA 11/6/00 FA	10:20 am ^{1 Yes 2 X No}	unk				
Division of Vital Records, rate or Attending Physician: The law required that death. In Directoral. After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and	Nymber of Rural Route Nymber, City			
Dj spital o hours a neral I	Cert	4 Homicide determined (Specify) Vacant he		Baltimore,	MD			
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, and rinvestigation, in my opinion, death occurred	due to the cause(s) and reat the time, date and place	manner as stated.			
To the within. To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		te signed (Month, Day, Year)			
		Marion Dr. Marie	O.C.M.E.	ļ	mber 7, 2009			
	}	30. Name and address of person who completed cause of death (Item 23a)					
		Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201				
St Regist		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Sarel					
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State of Maryland / Department of Health and Mental Hygiene 36283 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 3-34AM Miller 2009 Physician MYISTO 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cita Baltimore Medical center Baltimore Merity Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 2 Months 1 ₩ M 2 □ F 0 20-Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be netflied at 1 ☐ Yes 2 ☑ No Director OAK Homore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō SA 212 44 3648 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? , or items 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Black \$ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within it Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) NIA I 2 should be filed w h and Mental Hygier Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sheney W.'11 hristopher Michael 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st evertment of Health and Important; If item 27 Is r ny injury or other traur Laxisha Fitzgerald OAK mo LINGEN 21244 mother 20c. Location - City or Town, State Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Daltimore ew (a) 4 ☐ Donation 5 ☐ Other (Specify) 21227 21. Signature of Funeral Service Licenses Distak. 11020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onserand Death Immediate Cause (Final disease or condition resulting in death) da Treme **Physician** /Medical Due to (or as a consequence of): **Examiner** SEVELL KLS 1714970 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed obable Cor and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ned by the ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be detailed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Haemerrai 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 2 No 1 □Yes 2 XNo 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30/09 MICEIPOUR 00050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD 21202 Paul Place Baltmore MI) 301 APOOR SHIV 32. Registrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 50 PM **Physician** SHALL FFER O 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LOSPITAL AUTHOR N/A If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, May 31, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 😿 M 2 🗆 F Maryland 218-76-7311 42 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Medical Event must be notified at some. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Maryland Worcester Ocean City 1 ☐ Yes 2 🕅 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21842 USA 10437 Brighton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Sector Security Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Audrey Sue Sutherland Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10437 Brighton Road, Ocean City, Maryland 21842 19a. Informant's Name/Relationship (Type. Print) (Brother) Michael Marshall 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/10/09 Baltimore, Maryland Bayview Crematory, Inc. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McCully-Polymiak Funeral Home, F.A. 130 East Fort Ave., Baltimore, Marylani 21230 21. Signature of Fulneral Dervice Licensee Kevin E Ecker Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Rhos **Physician** weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the inector, page 2 s autopsy performed? 1 ☐Yes 2 No 1 ☐ Yes 2 D ours after death.

eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₽ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL PLACE TOSE 301 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Z 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar 36285 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 2009 MIROPOLSKY 6:00 P FEYGA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SEASON'S HOSPICE @ NORTHWEST RANDALLSTOWN BALTIMORE 9. Birthplace (State or Foreign Country)
UKRAINE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** 1 □ M 2 🕅 F Days Hours 08-02-1912 Months 213-33-3360 97 Director Usual Residence of Decedent 10a. State nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Midical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 SLADE AVENUE, #421 21208 UKRATNE Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. In the Property is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🜠 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BOOKKEEPER **BOOKKEEPING** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ SHLOMO MIROPOLSKY BELLA KOGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIMON BISNOVATY/SON SLADE AVENUE, #421, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUND 11-11-2009 BALTIMORE, MD 21. Sig Fture of Funeral Service Licen Fe 22. Name and Address of Facility SOL LEVINSON & BROTHERS 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final VESCALA Dementio disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine

Physician Medical Examiner

28a-f shov

with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and attending physician Medical Certificate: To Be Completed by Physician/Medical use a within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s

Division of Vital Records, P.O. Box 68760

if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):	
resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yo 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nhown
		24a. Was an autopsy grindings available prior to completion of cause of death? 1 \(\sum_{es} \) 2\(\sum_{es} \) No \(1 \sum_{es} \) 2 \(\sum_{es} \) No
25. Was case referred to medical examiner?	26. Place of Death (Check on	ly one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify) hospice Unit
27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1	l. Describe how injury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 L Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and diner: On the basis of examination and/or investigation, in my opinion, death occurred at the set Practioner: To the best of my knowledge, death occurred at the time, date and place a	time, date and place, and due to the cause(s) and manner stated.

29c. License number

DA7687

Restostown

MD

29d. Date signed (Month, Day, Year)

11/11/29

21136

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 12 2009

Raymond

Taymond Mille Mos

Milli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25 Man Street Smli

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/08/2009 Year **Physician** John J. Mutispaugh 2:30a ™ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 19 East Fort Avenue Baltimore N/A 8. Date of Birth (Month, Day, Year) 9/27/1949 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Hours Min. 1**⊠**M 2□F Months Days 219-54-4009 60 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" no the trainment. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County N/A MD 1 Yes 2 No Baltimore City Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19 E. Fort Avenue 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 ves 2 □ No If Yes, Give Year or Dates: US Army Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 □ Yes 2 No Specify: ρ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) ILA Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James R. Mutispaugh Harriett Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Mutispaugh / Son 413 Dominion Rd, Chester MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition **X**Burial 2 ☐ Cremation 3 ☐ Removal from State 11/11/2009 Baltimore Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD 21230 Approximate interval Between Ohset and Dea 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on e. in line. gode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Esquentially list on dillons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death Check online Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and hill of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death pitem 23a) (Type, Pri

1 2 2009

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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Kofi Nyanin	

	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2009 3628									
Physician/		rst, Middle,Last)				Date of Deat Month	th Day Year	3. Time of Death 2251 hrs		
edical Examiner	KUFI	institution, give street and	NY	ANIN 4b.	City, Town, or Location	October 2	9, 2009 4c. County of Deat			
		s Hospital Center	,		Cheverly		Prince Georg	e's		
Funeral Director	5. Social Security Number 220-51-178		7. Age (In yrs. las	-	If Under 1 Year If Und Months Days Hours	s Min.	h(MM/DD/YYYY) 9. Birthplace (State or Foreign Countrly HANA			
ий	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ir									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	MD MONTGOMERY GAITHERS						1 XYes 2 No			
the Maryland a or 28a-f sh tiffed at onc	10e. Street and Number		10f. Zip Code			Og. Citizen of What Country?				
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5-0036 ed within 72 hour lygiene. other than "natt he Medical Exar	Elemental y/Secondar	2YF		SE CU	RITY OFFICE	ER	PRIVAT	'E		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medivar		N L N Relationship (Type, Print)		19b. Mailing A		NA MENSHA-Boute Number or Rural Route Num		e, Zip Code)		
MD 2 shouth and 1 27 is umatic	7	NIM/BROTHER				RT SILVER S	PRING, MARYL	AND 20906		
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	20a. Method of Dispositi 1 Burial 2 C	tion Cremation 3 Removal		lace of Disposition	n (Name of cemetery, place)	Date	20c. Location - City of	7		
Page ment o	4 Donation 5 Other Specify: GATE OF HEAVEN 11/21/2009 SILVER						SILVER SP	RING, MARYLAN		
Ball permit Depart Impor	21. S nature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL 7474 LANDOVER ROAD LANDOVER, MARYLAND									
Physician		sease, or complications tha	t caused the death.	Do not enter the	mode of dying, such as	cardiac or respiratory and	rest, shock, or heart	Approximate Interval Between Onset and		
/Medical	Immediate Cause (Final	disease a Cardi	rdiac arrhythmia Death							
	or condition resulting in death) Due to (or as a consequence of): Dilated cardiomegaly									
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Records, The law require: ficate has been sig, page 2 should be Completed		completion of cause of								
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Sion Attendideath. Actor: by the f	1 X Natural 5	Investigation	N		1 Yes 2		(Stroot and Number or I	Pural Poute Number City		
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Hospin 24 hou Funer rely fil	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
Division of To the Hospital or Attending Phavithin 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral Medical Certification: T	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.									
Σ	29b. Signature and title of certifier				29c. License numbe	er	29d. Date signed (Month, Day, Year) October 30, 2009			
	30. Name and address	of person who completed of	cause of death (Item	23a)						
01	Carol Allan, ME				reet, Baltimore, M	ID 21201				
State Registrar	-796.0.797	lay, Year 2009	Registrar's Signatu	la de	. Al					
DHMH 17 Rev 1/2001				ORIGINAL						

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, Tre Medical Eventure for rottlind at any injury or other traumatic event, Tre Medical Eventure. Physicia /Medic Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	•	For State Registrar	State o	if Marylan	d / Depa <i>Cei</i>	artment of I rtificate of	Health and <i>Death</i>	Mental Hy	giene Reg. No.	2009	36288	
Physicia	an	1. Decedent's Name (First, Middle, Last)					-	2. Date of De	eath Day	Year	3. Time of Death	
/Medic		Carl		Offutt				Novemb	er 3',	2009	11:00 P ^M	
Examin	er	4a. Facility Name (If not institution,	-	mber)			or Location of Dea		1	ounty of Death		
Funeral		Holy Cross Hosp 5. Social Security Number	icai 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	r Spring	8. Date of Bir	th .	ntgome 9. Birth	nplace (State or Foreign	
irector		214-82-7842	1 ⊠ M 2□ F	39	Yrs.	Months Days	Hours Min		13, 197	70 Mar	intry) Yland	
or 28a-f show be notified at Director		Usual Residence of Decedent										
	٦ ا	10a. State 10b. County			y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	ect	Maryland Montgomery Silver				Spring 10f. Zip Code 10g. Citizen of 1				n of What Cou		
		3119 Hewitt Avenue, #498								d Stat	*	
ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.			S. 13.1	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				. Race - Amer		
or ite		1 X Never Married 2 ☐ Marrie	Armed Fo	2 🛛 No				to Rican, etc.)		Black, White	,	
ral',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:				1 □Yes 2 🛛 No	Specify:	Si	Specify: Black			
"natu	lete	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give			dent's Usual Occu kind of work done	orking	16b. Kind of Business/Industry					
t, tra Madical E	Ĕ	Elementary/Secondary (0-12)	1-4or 5+)		acher	work done during most of working T use retired)			Montgomery County Public Schools			
other ent, I	Be C	7. Father's Name (First, Middle, Last)			10	delici	me (First, Middle	(First, Middle, Maiden Surname)				
rked ic ev	To B	Daniel Offutt, Jr.					Constance Esther			Edwards		
umat		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	ng Address (Stree	t and Number or F	ural Route Numb	per, City or T	own, State, Z	ip Code)	
n 27 i ier tra		Darlene Baker /	Sister		3060	Bel Pre	Road, #1	04 , Silv	er Sp	ring, N	MD 20906	
if iten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	3 □ Removal from	State 20b. F	Place of Dispo emetery, crer	sition (Name of natory or other pla	nce) Nove	Date ember	20c. Loca	tion - City or T	Town, State	
tant: Jury		4 ☐ Donation 5 ☐ Other (Spe	ecify)	Par		morial Parl	k 9,	2009	Rocky	ille,	Maryland	
mpor any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc.										
_ , ,	-	Molos Maryland 20850–2805										
		23a. Part1. Exfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
sician edical		Immediate Cause (Final disease or condition resulting In death) Brain Mass Due to (or as a consequence of):										
miner		Y				ifocal Le	ukoencep	halopath	ıv			
Į	ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D.	(of as a conseq					- J			
j pnysician and s the burial-transit		the daying to immediate cause. Enter Underlying Cause, Disease or injury that initiated events acquired Immune Deficiency Syndrome C. Acquired Immune Deficiency Syndrome										
ourial-		that initiated events resulting in death) Last C. Acquired limmune Deficiency Syndrome Due to (or as a consequence of):										
the	edical		d					_				
ise as	/Me	IF FEMALE:	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delivery		New York				
for u	ciar					Month Day Year						
etached for use a Physician/M	hysi	9 Unknown										
e det	by P	Part II. Other significant condition	nderlying cause given in Part I. 23e. Die			d tobacco use contribute to the cause of death?						
ald by					1 🗆]Yes 2 X No 3 ∏ Probably 4 ∏ Unknown						
2 sh	Completed							24a. Was			topsy findings available	
page	Soil							perf 1 □ Yes	ormed? 2 X No	death?	2 □ No	
ector,	0	25. Was case referred to medical examiner?	l la anital					ath (Check only	one)			
al dir	은	1 ☐ Yes 2 🔯 No 27. Manner of Death	Hospital: 1 🔀	Inpatient 2	ER/Outpatier	11 3 LI DOA		Home 5 ☐ Res			cify)	
funer	tion	1 Natural 5 ☐ Pending	(Mor	oth, Day, Year)	Injury	Wo	aryat ork? ⊒Yes 2 ⊟No	28d. Describe	now injury o	occurrea		
by the	fica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, str				28f. Location	If. Location (Street and Number or Rural Route Number,					
ed in !	Certification:	4 Homicide determined building, etc. (Specify)										
	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
romp comp	Me	29b. Signature and vitte of certifier					29c. License number			29d. Date signed (Month, Day, Year)		
		► AVVUMM/ mD DG3579							November 3, 2009			
		30. Name and addr st of person who complited bluse of death (Item 23a) (Type, Print)										
	6.5	Maria J. Tayag, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910										

Registrar

NOV 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 9 7 11:45A M Owens June Rose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 - 25 - 1940 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland Months Days Hours Min. 1 □ M 2 📉 69 Director 214-38-2927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ite Markical Example view in thind at any injury or other traumatic event, ite Markical Example or with the indifficult and interest and injury or other traumatic event, ite Markical Example. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Carroll Westminster MD 1 □Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21157 USA 42 Hillside Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No Specify Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Sales Cosmetics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Naditch James Fisher ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
One Slade Ave., Suite 108, Baltimore, MD Ronald Naditch-cousin 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 11-12-09 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service License homas <u> 254 E. Main St., Westminster, MD 21157</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 8/26/06/06/01/1/69 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to intercept cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Justo (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and attending physician and for use as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate 2 □ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

tER Street WESTHIUSTER, MD 21157

38. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

09-08678 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 36290 Anne Payne State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 8, 2009 0632 hrs Medical Examiner Payne Anne Marie 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Bayview Hospital **Baltimore** 5. Social Security Number 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Director 219-80-0513 39 9/14/1970 M 2 X F Marviand Usual Residence of Decedent any 10a, State 0c. City, Town or Location 10d. Inside City Limits 10b, Count or 28a-f show 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. MD Baltimore Baltimore hours after death with the Maryland rector 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 2971 A Dummurray Road 21222 U.S.A. ā 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funer 1 X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Whita, etc. 2 Yes 2 X No 0 _{Specify:} White 3 Widowed 4 Divorced If Yes, Give Yea 1 Yes 2 X No specify: Examiner "natural" þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hormont of Health and Mental Hygiene reparts. If item 27 is marked other than "na yor other trannatic event, the Medical Exp. Elementary/Secondary (0-12) College (1-4 or 5+) 12 2 Cab Dispatcher Transportation 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Eugene Martin Payne Phylis Jeanne Kholhoff ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Tolasky/ Daughter 2917 A Dummurray Road, Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) permit. Pages
Department of
Important: I Anatomy Gifts Registry 11/12/2009 Hanover, Maryland Other Specify: 4 X Donation 5 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medica a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) for Yes 2 No 9 ✔ Unknown Unknown Icate has been signed by the page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an autopsy After this certificate has performed' death? Yes 2 V No Yes 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner Other₄ 2 V ER/Outpatient 3 Inpatient Nursing Home 5 Residence 6 Other: ဥ 1 V Yes No 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 1 Yes 2 No Pending Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined Homicide

MDApproximate Interval Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of 2 No completely filled in by the funeral director, Certification: To the Hospital or Attend within 24 hours after death 28f. Location (Street and Number or Rural Route Number, City To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 9, 2009 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month-Day, Year) **State** Registrar Dawie IZ Rev IZUU ORIGINAL **OCME 2006** OCME

09-08606 Aretha Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 3629 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	ertificate of	Death		Re	9. No.	,
Physici edical Exami	an/	1. Decedent's Name (First, Middle, Li Aretha Rene	,	Parke	r		2. Date of Deat Month November	Day Year	3. Time of Death 1524 hrs
		4a. Facility Name (if not institution, g 1344 Druid Hill Avenue A		4	b. City, Town, or L Baltimore	ocation of Death		4c. County of De	ath
Funeral Director		222 54 55	Sex 7. Age (In yrs.	last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	1		Birthplace (State or eign Country) MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-fshow any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD N 10e. Street and Number 1344 Druid Hi 11. Marital Status Never Married 2 Marrie	11 Avenue 12. Was Decedent Ever in Uarmed Forces? 1 Yes 2 X No ed If Yes, Give Year only highest grade completed) College (1-4 or 5+) St) PC (Type, Print) Removal from State Gradies Removal from State Armed Forces? 1 Yes 2 X No ed If Yes, Give Year 1 Oct. City Armed Forces? 1 Yes 2 X No ed If Yes 3 X No 2	y, Town or Location Baltim J.S. 13. Was If Ye 1 1 16a. Decedent during more during more during more points and the cree 19b. Mailing 19 15 A 1. Place of Disposit crematory or other more points and crematory or other more poi	ore 10f. Zip Code 21 s Decedent of Hisp ss, specify Cuban, Yes 2 X No 's Usual Occupation ousekee Address (Street rlingto tion (Name of center place) rown F/ atory ame and Address	Mexican, Puerto specify: on (Give kind of v DO NOT use reti eping 18. Mother's Name Ida t and Number of I on Ave. netery, H 11/-	vork done red) (First, Middle, North Rural Route Numple Balters 13	Og. Citizen of What C U.S.A. 14. Race - An White, etc Specify: B1 16b. Kind of Busines Pimlico Maiden Surname) Turner ther, City or Town, St O., MD 2 20c. Location - City Baltimo	ack ss/Industry race track ate, Zip Code) 1217 ror Town, State re, MD
Physician /Medical %aminer		23a. Part I. Enter the disease, or corfeilure. List only one cause on Immediate Cause (Final disease or condition resulting in death)		th. Do not enter th	ne mode of dying,	such as cardiac o	Ve., B	uneral H alto., M est, shock, or heart	OME D 21217 Approximate Interval Between Onset and Death
ted 1 insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence c. Due to (or as a consequence						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after card. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by Physiciar	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown Part II. Other significant condition	23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of c	egnancy 2 Fel death 5 Oth	ner (Specify)	Ectopic pregna	ancy 23e. Did to		very Day Year to the cause of death? Probably 4 V Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rand catal. After this certificate has been signed by led in by the funeral director, page 2 should be detach	Be Completed	25. Was case referred to medical			26.Place	of Death (Check	1 🗸 Yes	osy prior rmed? deat	
Vita	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	obon		ng Home 5	Residence 6 🗸 C	ther: Scene
Sion of Attending Phenical Afternation of Colors, Afternation by the funeral systems of the		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investig		28b. Time of I		ry at Work? Yes 2 No	28d. Describe	how injury occurred	
Division pital or Attencours after death reral Director:	Certification:	3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of Injury - At	home, farm, stree	et, factory, office b	uilding, etc.	28f. Location (or Town, S		r Rural Route Number, City
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical (ician: To the best of my knowle ner:On the basis of examination and manner stated.						
	Ž	29b. Signature and title of certifier	1 - 0		29c. Licens			29d. Date signed	
		larde A	allan		0.C.I	W.E.		November 6,	2009
	0 1	30. Name and address of person wh Carol Allan, MD Assis	o completed cause of death (Ite tant Medical Examiner		Street, Baltime	ore, MD 2120)1		
S Regis	tate trar	31. Date filed (Month, Day. Year)	34. Registrar's Signa		V				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08691 2009 36292 State of Maryland / Department of Health and Mental Hygiene Jerome Pinkney 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Physician/ Month Day November 8, 2009 1600 hrs Jerome Medical Examiner 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Bayview Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY g. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Min Country) Maryland Director 65 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No , or items 23a or 28a-f show r must be notified at once. Mary land Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10g, Citizen of What Count 10e. Street and Numb 6002 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in UپS White, etc traumatic event, the Me lical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Married Yes Yes 2 No specify: Divorced If Yes, Give Year Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Disabled MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Unknown unknown Be 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type, Print) ٥ Baltimon Celestine Pinkney-daughter Plain item 27 20b. Place of Disposition (Name of cemetery, 2 Cremation 3 Removal from State Important: Other Specify Donation 5 21. Signature of Fundra Service Lice Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial -23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate has ✓ Yes 2 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be Hospital: Other 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 Yes Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 V Natural Yes 2 No Pendina 24 hours after death. Funeral Director: the Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. November 9, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009 **Physician** 01:30 AM rince /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year Days Months 1**X** M 2□ F 50 Director 218-78-1162 Oct. 12, 1959 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1992 Poplar Ridge Road 21122 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Tech Support 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Prince, Sr. Jean မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry L. Prince (Wife) 1992 Poplar Ridge Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 11/11/09 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licensee McCully Polyniak Funeral Home, P.A. CU 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ordio polmonaro if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SERVICE OF MENCAL PLANTINGS Examiner death certificate be executed chest Due to (or as a consequence of) physician the burial Physician/Medical as attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s autopsy 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Crushed under vehicle while 10 3 2009 17:00 PM 1E 18e. Pt. e of hiury - At home, farm, street, factory, office building, etc. (Specify) 1 □Yes 2 XNo 28f. Location (Street and Number or Run Route Number, City or Town, State)
8400 Forest Dr. Anne Ar 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide street near home 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatui nd title of certifier

Records, of Vital To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Division

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Baltimore, Maryland 21215-0036

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stancie C. Rhodes 22 S. Greene St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature MOA T & SOOR

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D0065118

Battimore, MD

2009

State of Maryland / Department of Health and Mental Hygiene, 36294 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:00 a.M Anne Tobin 9, Perry November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City Town, or Location of Death 4c. County of Death **Examiner** 9707 Old Georgetown Rd. Bethesda Montgomery 8. Date of Birth (Month, Day, Year)
Oct. 18, 19 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 X F 97 1912 Illinois Director 578-46-3176 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner hast be notified at Director 1 ☐Yes 2 X No Montgomery MD Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 9707 Old Georgetown Rd. Apt. 2404 20814 23a United States Funeral Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 21 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Architecture Interior Designer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Tobin ဂ္ Anna Lardner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra David Perry (step-son) 644 E. Street, N.E., Washington, DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Nov. 11, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Coneral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service XX 933 Gist Ave. Silver Spring, MD 20910 M00982 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): 68760, attending physician for use as the burial Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒ No Month Vear Day 5 Other (specify) P.O. 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ğ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 20⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26259 November 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Ave. #103 Bethesda, Maryland 20814 Ava Kaufman, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 Registrar

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	Physi Mo	cian/ dica	/	1. Decedent's Name (F										2. Date of De	ath		ზშ9	3. Time of Death 1:45 A M
	Exan			4a. Facility Name (if no		ve street an	d number)				Town, or	Location o	of Death		40	BAL	of Death	RE
	Funer Direct			235-34-522	20	Sex 1 M 2	7-1	(In yrs. Ias 83	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir APRIL	$1^{Y_{ear}}$	1926		ace (State or Foreign Y VIRGINIA
10, 2009 1;45 a.m.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at.	To Bo Completed by Europa Disactor	e Completed by Funeral Director	MD 10e. Street and Number 6400 HAZEI 11. Marital Status 1 Never Married 3 Widowed 4 (Specification of the content of the c	BALT er LWOOD A 2X Marrier Divorced 15. Decedent's y only highest day (0-12) st, Middle, Las EOLIO e/Relationship	12. Was Arm 1	Decedent Eved Forces? Yes 2 A N s, Give or Dates.	rer in U.S.	16a. Decedor (Give kife. DCBEAUT	LE 10f. Zip 2. /as Decece Yes, spec Yes Usuaind of work ind of work ICTAI	ent of His ify Cubar 2X No No No No (Street a	Specify: tion uring most 18. Mothe MARI	t of working er's Name EBI er or Rura	e (First, Middle, TTY	16b. B B Maiden	Specify: Kind of Bus EAUTY Surname)	- America , White, et WHI' SHO	n Indian, tc. ΓΕ ustry
NOVEMBER 10,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra	once.		WILLIAM PF 20a. Method of Dispos 1 XBurial 2 4 Donation 5 21. Signature of Funer	sition Cremation 3	☐ Remova		cer	ce of Dispos netery, crem DENS 0	sition (Name latory or o F FA	ne of ther place TH		11/ y MI	ALTIMOR Date 13/09 LLER-D1 BALTIMO	20c. L BA	ocation - 0 LTIMO L FUN	RE, I	
	certificate be executed y the	al	iicai EXamilirer	23a. Part Ent r the hook, or leart fill Immediate Cause (Fir disease or condition resulting in death) Sequentially list cond if any, leading to immediate. Enter Underlyi Cause (Libease or ling) that initiated events resulting in death) Las	ailure. Let Annal itions, ediate ng ury	a. S b. D	that caused to on each line. EPSIS Lie to (or as a line to (or a) line to (conseque	nce of):	r the mod	e of dying	, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
Bov 687	the death certificate by the attending phrached for use as th	Physician/Med	nysician/med	FFEMALE: 23b. Was decedent proint the past 12 mo 1 ☐ Yes 2 🛣 1 9 ☐ Unknown	nths?	1 <u> </u>	s, outcome o Live Birth 2 Pregnant at Unknown	Fetal o	death 3 🗌	Ectopic p		1				23d, Date Mont		y Day Year
THERESA PFEIFER	The law requires that cate has been signed I page 2 should be det	Completed by	completed by	Part II. Other signifi ca		contributin	g to death bu	t not result	ting in the ur	nderlying (ause give	en in Part I	i.	1 🗆 24a. Was auto	Yes 2 an psy prmed?	No 3	Proba	ably 4 Unknown Sy findings available poletion of cause of
THERESA PFE	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Certificate: To Be		2 Accident		ion be 28e.	1 ☐ Inpatier Date of injury,(Month, Day,	Year) 2	8b. Time of injury	M 2	Othe Bc. Injury work?	4 L Nu at	irsing Ho	me 5 Residence R	now inju	ry occurred	i ,	HOSPICE Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director A completed filled in by the f.	Medical	IMEGICAL	29a. Certifier 1 Check 2 Conly one) 3 X 29b. Signature and titl	Medical Exa Certifying N	miner: On the	ne basis of exa oner: To the b	amination a est of my k	and/or investi knowledge, d	gation, in I	ny opinio	time, date	curred at	d due to the ca the time, date a e, and due to th	and place e cause(e, and due t	o the caus ner as stal	se(s) and manner stated red.
4	S Regis	tate strar	3	JACKIE JO		RNP	2300, D 32. Registrar	ULANI	Y VAL		D.	TIMO	NIUM	, MD 21	.093		·	

State of Maryland / Department of Health and Mental Hygien ? 36296 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 06 2009" **GLADYS** 9:00A M PERLMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOLDEN LIVING CENTER WESTMINSTER CARROLL 8. Date of Birth 04/13/1920 Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 167-16-4800 1 □ M 2 X F PA 89 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 219 BERTIE AVENUE 21157 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE δ Specify: Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK/TYPIST FURNITURE marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked ofth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY TINKEL IDA FISHMAN မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOY BOSCH/DAUGHTER 219 BERTIE AVENUE, WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemerary prematory profiler place)
ANSHE SFARD AHAVAS 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/09/2009 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service License Tobel 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 tource **Physician** 24ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a sensequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Examir physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Day Month Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a Was an certificate 1 ☐ Yes 2 ☐ No : After this certification : 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟Yes 2 🖼 Ho 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ello 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin GHAUL 31. Date filed (Month, Day, M Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36297 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11 -07 - 200 gay Jacob A. Quiring 1145 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 1. (Month, Day, 9. Birthplace (State or Foreign Funerai 1 🛛 M 2 🗆 F 1 1 Day 932 76 Director 338-26-7574 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Harford Forest Hill 1 ☐ Yes 2X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 USA 3410 Kreitler Rd "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give 1 Never Married 2 Married ģ 2 🗌 No Maryland 21215-0036 1 Tyes 2 No Specify. Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) of Machinery Fairlanes Bowling Equp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob Quiring Mary Leitham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Quiring (Wife) 3410 Kreitler Rd Forest HI11, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gardens 11-11-2009 Fallston, MD 4 Donation 5 D Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset Ind Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) 520011 COI Lino Medical Due to (or as a consequence of): Examiner Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 \square No detached 9 Unknown 9 Unknown Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pec signt I be o Completed by 1 Yes OUSTICETURE DUMONORY 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform funeral director, page 2 Hospital or Attending Physician: The certificate **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\subseteq \text{ Nursing Home 5 \subseteq \text{Residence 6 \text{ Nother (Specify) } } \) 2**X** № မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29d. Date signed (Month, Day, Year)

State

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39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Regil trar's Signature

09-08612 Jason Lee Robinson . Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene .

2009 36298

	J	1- For State Registrar			Certifica	ate of	Death			Reg	. No.		
Physicia Vedical Examin	n/	Decedent's Name (First, Midd Jason Lee	_{le,Last)} Robinsc	n						Date of Death Month I November 5	Day 5, 2009	Year	3. Time of Death 2210 hrs
		4a. Facility Name (if not institution 916 Eastham Court			_	41	Crofton	Location of		tovombor	4c. Cou	unty of Death Arundel	
Funeral Director		5. Social Security Number 219-04-4725	6. Sex		yrs. last birth	Yrs.	If Under 1 Year Months Days		24Hrs. 8 Min.	8/21/1	`	Foreign	nplace (State or notes) notes)
Maryland 28a-f show any 1 at once,	ō		Arundel		Croftc		n Tildage	23					10d. Inside City Limits 1 Yes 2 X No
with the Maryland ins 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 916 Eastham (Court T3				10f. Zip Code 21114			10g	g. Citizen o U • S	of What Coun	try?
er death	by Funeral	3 Widowed 4 Div	Armed 1 Yes vorced If Yes, Give Yor Dates:	'ear	No	If Ye	Decedent of Hisps, specify Cuban,	Mexican, F	Puerto Ric	ean, etc.)	Spec	white, etc. _{cify:} Whi	
15-0036 filed within 72 hours Hygiene, d other than "natur the Medical Exam	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12		(1-4 or 5+)		luring mo	s Usual Occupationst of working life. Chanic					of Business/Ir	·
21215-0036 Juld be filed within 7 Mental Hygiene Hannarked other than the event, the Medica	Be	17. Father's Name (First, Middle Michael Doug.	las Robi	nson.]1	18.Mother's Lora	_ `	rst, Middle, Ma n Lee	aiden Surn	ame)	
e, MD 21 I and 2 should Health and Mer item 27 is man r traumatic ev		19a. Informant's Name/Relations Lora Johnson/			7	901	Address (Street Laurel L	akes	Cour	t #115	, Lau	rel, M	ID 20707
Pages eent of nnt: If		20a. Method of Disposition 1 Burial 2 Cremation 4 X Donation 5 Other S	-	from State	cremato	Gift	s Registry	7	11/1	2/2009	Hano		Maryland
Balti permit. Departur Imports		21. Signature of Funeral Service	Licensee			22. Na	ime and Address 22 Conne	of Facility	Anat Dr.,	omy Git Ste. I	fts R P, Ha	Registr nover,	Y MD 21076
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final disease	on each line.				e mode of dying,	such as car	rdiac or re	spiratory arres	st, shock, o	or heart	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death)		a conseque									
	Ęŀ	Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated	C	a conseque									
760, Toate be executed sphysician and the burial - transit		events resulting in death) Last	d	a conseque	nce of):								
O, e be ex sician burial	影	UNPENDED	AMENDE										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in topast 12 months? 1 Yes 2 No 9 Un	1 Live	s, outcome of e birth gnant at time known	2		al death 3 er (Specify)	Ectopic	pregnancy	,	23d. Da Mor	ate of delivery onth D	ay Y ear
P.O. Erres that the signed by the be detached	≥	Part II. Other significant condi	tions contributing	to death but	not resulting	in the ur	iderlying cause gi	iven in Part	t I.				he cause of death? ably 4 Unknown
of Vital Records, in Physician: The law require the third this certificate has been a meral director, page 2 should	Completed									24a. Was ar autops perform	y ned?		opsy findings available ompletion of cause of
Vital Rec	ω	25. Was case referred to medica examiner?						of Death (C	Check only				
Vit	<u> </u>	1 ✔ Yes 2 No	Hospital: 1	Inpatient		tpatient			Nursing H			6 🗸 Other	Scene
ion of tending P leath. tor: After the funera	ertification:	27. Manner of Death 1 Natural 5 Pen 2 Accident Inve	Moi (Moi	te of Injury nth, Day Year) , 2009	28b. T 2101	ime of In		y at Work? 'es 2 ✔ 1	Isı	d. Describe ho ibject shot		ccurred	
Division pital or Attendir ours after death. reral Director: A) -	3 Suicide 6 Cou 4 Homicide dete	ld not be 28e. Pl	ace of Injury Single		rm, street	, factory, office bi	uilding, etc.		f. Location (St or Town, Sta 6 Eastham C	ate)		ral Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b	edical	one) 2 Medical Exa	and manne	s of examina			on, in my opinion,	death occ					
	Σ	29b. Signature and title of certific	Hall	lev			29c. License O.C,N					signed (Mor ber 6, 200	oth, Day, Year) 9
Ø,			sistant Medica	al Examine	er 111 F	Penn S	treet, Baltimo	ore, MD 2	21201	·			
Sta Registr	_	31. Date filed (Month, Day, Year)	2 2009 32.	Regular's S		8	ale						

OCME

			State of Maryland / Dep	artment of Health and Nartificate of Death	Mental Hygie Reg		36299
4	Physici		1. Decedent's Name (First, Middle, Last) Mildred M. Rixham		2. Date of Death Month	Day Year 8 ~ 09	3. Time of Death 5:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Manor Care— Ruxton	4b. City, Town, or Location of Death Towson	-	4c. County of Death	alto.
1	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday 1 M 2 XF 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y May 11,19	'ear) Cour	olace (State or Foreign htry) yland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Once.	To Be Completed by Funeral Director	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 12th 17. Father's Name (First, Middle, Last) William Wiegmann 19a. Informant's Name/Relationship (Type. Print) William F. Rixham Son 10b. Mai 20a. Method of Disposition 1□ Burial 2 □ Cremation 3 □ Removal from State 4□ Donation 5 □ Other (Specify)	Bel Air 10f. Zip Code 21015 Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify: edent's Usual Occupation ekind of work done during most of work DO NOT use retired) temaker 18. Mother's Nam M. Mac Augustion (Street and Number of Ru 402 Turret Road consition (Name of ematory or other place) of Faith 11-1	pecify Yes or No- o Rican, etc.) king ne (First, Middle, Ma deline Lec iral Route Number, (Bel Air, N Date 20 2-2009 Ba chimunek	g. Citizen of What Cour USA 14. Race - Americ Black, White, Specify: Wh Sb. Kind of Business/In Ho aiden Surname) onard City or Town, State, Zip	can Indian, etc. nite dustry Dime Code) Down, State
8/60,	Cate be executed physician and physician and the burial-transit the burial-transit physician and the burial-transit physician and the burial-transit physician and the burial-transit physician and the burial-transit physi	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying, such as cardiad	c or respiratory arres	st,	Approximate Interval Between Onset and Death
Vital Records, P.O. Box 68	requires that the death certiff been signed by the attending hould be detached for use as	Completed by Physician/Medi		□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	1 ☐ Yes 24a. Was an autopsy performe	ed? prior to co	Day Year the cause of death?
Division or Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has be completely filled in by the funeral director, page 2 s	Medical Certification: To Be C	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No street, factory, office ath occurred at the time, date and place investigation, in my opinion, death occurred.	ath (Check only one) home 5 Residen 28d. Describe how 28f. Location (Stre City or Town, e, and due to the cau	nce 6 □Other (Special vinjury occurred set and Number or Rur State) use(s) and manner as a te and place, and due to	ral Route Number, stated. to the cause(s)
	To To COF	2	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Typ Cyrus Asadi, 696 Hamme	How 5 44	Brack!	d. Date signed (Month,	21225
ı	Sta Regist	ate rar	31. Date filed (Month Pay Year) 2009 7. Registrar's Signature	ald		7.770	

State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

36300

hysician
/Medical
xaminer

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar					lineat	6 01	Deali	<i>'</i>		Reg.	No.			
n al	1. Decedent's Name Freder:			h						2. Date of D Month		Day	2009 2009	3. Time o	of Death A M
er	4a. Facility Name (I	f not institution, g	ive street and number)			4b. City,	Town, c	r Location	of Death			4c. Cour	nty of Death		
	370 Jami							ırnie				Anne	Arun		
	5. Social Security N		Sex 7. Ag 1₺ M 2□ F		last birthday, Yrs.	If Unde Months	r 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of B (Month, I Aug •	irth Day, Ye	ar)	9. Birth Cou Mary	place (State ptry)	or Foreign
	216-32-31 Usual Residence of			73	115.				<u> </u>	Aug. 3) L ,	1930	Mary	Tand	
	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation	-							10d. Inside (City Limits
Ď	Maryland	Anne Aı	undel	Gle:	n Burn	ie								1 □Yes	s 2 🖰 No
irec	10e. Street and Nur	mber				10f. Zip	Code				10g.	Citizen o	of What Cou	ntry?	
a	370 Jamie	Ct.				210	60				Un	ited	Stat	es	
ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Dece	dent of h	lispanic C	rigin? (Sp	ecify Yes or N Rican, etc.)	10-		tace - Ameri		
7		ed 2 Married		No		1 ☐ Yes		Specif		rtioan, cto.)		Spec	oifu		
0	3 Widowed		Year or Dates:										WII	ite	
ere	(Spec	15. Decedent's l cify only highest g	Education rade completed)		16a. Dece	edent's Usu e kind of wo DO NOT u	al Occup ork done	during mo	st of work	ing	16b	. Kind of	Business/Ir	dustry	
Ĕ	Elementary/Seco	ndary (0-12)	College (1-4or 5	i+)	Meat							Groc	ery S	tore	
Be Completed by Funeral Director	17. Father's Name ((First, Middle, Las	st)			<u>-</u>			her's Nam	e (First, Middl					
0	Earl Rut	h						Es	ther	Munks					
	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mail	ing Address	s (Street	and Num	ber or Rui	ral Route Num	ber, C	ty or Tou	vn, State, Zi	o Code)	
	Eva L. D	urm / Da	ughter		370	Jamie	Ct.	, G1	en Bu	ırnie,	Mar	y1an	d 210	60	
	20a. Method of Disp		_	20b. P	Place of Disp emetery, cre	osition (Na	me of	cel	Nov.	Date O	200	. Locatio	n - City or T	own, State	
		XICremation 3 5.☐Other (Spec	☐ Removal from State		ro Cr				200	i9 [°] ,	Ca	tons	ville	, Mary	land
	21. Signature of FD	cal Service Lic	ensee		v ²	2. Name a	nd Addre	ess of Faci	lity	1 II	2=2	D	Λ.		
	产一	Myol			2	21 Cr	y-Ru ain	Hwy.	, S.E	eral H E., Gle	ome n B	urni	e, MD	2106	51
	23a. Part 1. In er ti	he disease, or co	mplication to caused y one cause on each lii	the death	n. Do not en	iter the mo	de of dyi	ng, such a	s cardiac	or respiratory	arrest,			Approxima Interval Be	ate etween
	Immediate Cause ((Final		14057	Hul	He	ant	F	all	re				Onset and	Death
	resulting in death)	4	Due to (or as	a consequ	uence of):		- (-(+1						
	Sequentially list cor	nditions	b												
5	cause. Enter Unde Cause (Disease or	rlying	Due to (or se	d conesq	uence of):										
an/medical Examiner	that initiated events resulting in death) I		C												
i i	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Due to (or as	a consequ	derice oi):										
3			d									-	+		
ME	IF FEMALE:		23c. If yes, outcome	of pregna	incv							004 [Date of deliv	10.77	
Clar	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death 3	☐ Ectopic ☐ Other (s	pregnano	СУ					Month	Day	Year
38	1 □ Yes 2 □ 9 □ Unknown	_1M0	9 Unknown												
Completed by Physicia	Part II. Other signif	icant conditions	contributing to death b	ut not resu	ulting in the u	inderlying o	cause giv	en in Part	1.	23e. Dio	l tobac	co use co	ontribute to	the cause of	death?
ם ס										1 🗆	Yes	2 No	3 □ Pro	bably 4□	Unknown
Jete										24a. Wa	s an	24		opsy finding	
=										_ per	opsy formed		death?	impletion of	cause of
2	25. Was case refer	red to medical						26. Plac	ce of Deat	1 ∐Yes h (Check only		HO	1 ☐ Yes	2 12 110	
	examiner? 1 ☐ Yes 2 ☐		Hospital:	ent 2 🗆	ER/Outpatie	ent 3 □ De	OA Oth	or:	Vursing Ho		_	e 6∏0	Other (Spec	ify)	
	27. Manner of Death	h	28a. Date of Inju	iry	28b. Time o		28c. Inju Woi			28d. Describe				-77	
2	1 □ Natural 2 □ Accident	5 ☐ Pending investigati	on	y, rear)	injury	М		Yes 2	□No						
2	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine		ury - At ho	ome, farm, st	reet, factor	y, office			28f. Location City or To	(Stree	t and Nui	mber or Rui	al Route Nu	mber,
3			- Linding, or	, _ , _ , _ , _ , _ , _ , _ , _ , _ , _						J., J. 1	, 0				
medical certification: 10	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis o and manner sta	f examina											(s)
1	29b. Signature and	title of certifier	00+	^	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	29	c. Licens	se number	211		29d.	Date sig	ned (Month	Day, Year)	
	> 5 M	lett)	Wall	W/	1		100	160	94			11	109/	9	
	30. Name and addr	ess of person wh	o completed\cause of d	eath (Item	23a) (Type	Print)		1 11	А	. [1	2	1		1	9/1
	Ellust	Forbo	1. 601	141	Il M.	adsk	n P	ark	MU	v, ol	al	IUN	ueju	9,21	06/
	31. Date filed (Mont	th, Day, Year)	32. Régistr	ar's Signa		. 0 -								-1	t
		MARY	CUUS Server	M	A. A.	Back	h								
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DHMH 17 Rev 1/2001

Stat Registra

DHMH 17 Rev 1/2001

			For State Registrar	Amend I	State of Ma tem 8 per	ryland En, g906	Depa 5,087 Cert	tment of b 0472010 ificate of L	lealth and I hb Jeath	d Me	ntal Hy	giene Reg. No.	2009	36302
	Physicia	n/	1. Decedent's Name (*	-				2.	. Date of De			3. Time of Death
	Medic	al	TERRY			ROG	ERS				CTOBER	- 25	260	9 06:55 AM
	Examin	er	4a. Facility Name (if no		street and number) WEDICAL	CONT	n	4b. City, Town, or	Location of De			4c.	County of Dea	ath
	Funeral		5. Social Securify Num	nber 6. S	ex 7. Age	(In yrs. last bii	rthday)	If Under 1 Year Months Days	If Under 24 H	Irs. 8.	Date of Bird			irthplace (State or Foreign
	Director		577-86- Usual Residence of De	0011	5 M 2 □ F	49	Yrs.	Months	Hours Wi	0	37197	1960	Wo	country)
	and show	tor	10a. State	0b. County		10c. City, Tov								10d. Inside City Limits
	Mary 28a-f otifie	Director	MD,	Montgi	onery	KER	1511	rotor	<u> </u>					1 ☐ Yes 2 ☑ No
	th the 3a or t be n	ral D	10e, Street and Number	er	ell Pla			10f. Zip Code	902				izen of What C	
	ems 2	Funeral	11. Marital Status	Low	12. Was Decedent Ex		13. W	as Decedent of Hi		(Specify	Yes or No-		14. Race - Am	
36	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at	by	1 ➡ Never Married 3 ☐ Widowed 4 [Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	10	lf'	Yes, specify Cuba □ Yes 2 \ No	n, Mexican, Pue	èrto Ric	an, etc.)		Black, Whi	
215-0036	hours natura lical E	lete		15. Decedent's E	Year or Dates.	168		nt's Usual Occupa		_	-		nd of Business	
21	nin 72 ne. .han " l	Completed	(Specify Elementary/Second	fy only highest gra day (0-12)	ade completed) College (1-4 or 5-	-)	life. DO	nd of work done d NOT use retired)	,	vorking				uction
2	lled with Hygier other t	BeC	17. Father's Name (Firs	et Middle Last			10	ontrac		1				uction
Maryland 21	ould be file id Mental marked c matic eve	욘	Willia		VANFOS	sen			18. Mother's N			De l'		
lary	should and N is ma auma		19a. Informant's Name		/ 0		b. Mailing	Address (Street a				r, City or	Town, State, Z	ip Code)
	1 and 2 if Health item 27 other tr		1err) 20a. Method of Dispos	1, 1	ranco			5 Car	-oline					
Baltimore,	Page nent o ant: If iry or			Cremation 3	Removal from State (fy)			tion (Name of itory or other place	e)	Date 3	-09	20c. Lo	cation - City o	r Town, State r Yan Va.
Batt	permit. Departn Importa any inju		21. Signature of Funer	al Service Licens	(L)hnsu		22.	Name and Address	s of Facility	ew	410	Lun	eral 1	Home
			23a. Part 1. Enter the	disease, or com	plications that caused the cause on each line.	the death. Do					spiratory an		VIIG	Approximate
7	Inysician / Medical	e 4	Immediate Cause (Fin disease or condition resulting in death)		a. GAS			wat	BLEED					Interval Between Onset and Death 12 HOUSES
	Examiner		resulting in deathy	ſ	Due to (or as a	•	•	(RRHOSI)	c					YEAKS
	_	iner	Sequentially list condi if any k acing to imme cause. Enter Underlyii	aclista .	b. Due to for as a									, CPIZS
ĺ	ecuted and transit	Examiner	Cause (Disease or iinj that initiated events resulting in death) Las	ury	c Due to (or as a	oonaaguanaa	26:							
_	cate be executed physician and the burial-transit	edical E	resulting in death) Las	L	Due to (or as a	consequence	Oi).							
% %	ficate g phys as the	Nedi			d							_		
χ	th certite tending or use	ian/	IF FEMALE: 23b. Was decedent pre in the past 12 mo	cgilant	23c. If yes, outcome of	f pregnancy	th 3 🗆 :	Ectopic pregnanc	у			2	23d. Date of de	,
Box	he deal y the at ched fo	by Physician/M	1 Yes 2 N		4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗆	Other (specify)					Month	Day Year
л Э	that the ned by e deta	S P	Part II. Other significa	int conditions or	ontributing to death bu	t not resulting	in the und	derlying cause give	en in Part I.		23e. Did to	bacco us	se contribute t	o the cause of death?
ďS,	quires en sig ould b									-	1 🗆 '	Yes 2	No 3 □ F	Probably 4 🗆 Unknown
Records,	law re has be e 2 sh	Completed								- [24a. Was a autop	sy	24b. Were as prior to death?	utopsy findings available completion of cause of
Ĭ	n: The ificate or, pag		25. Was case referred t	to medical				06 81-			1 Yes	2 No		es 2 🗆 No
от Vital	ysicia is certi directo	To Be	examiner?	/ 14	Hospital:	nt 2 🗆 ER/O	utpatient	Otho	r: 4 Nursing		, , ,	lence 6	Other (Spe	cifu)
T 0	ling Ph		27. Manner of Death 1 Natural 5	5 ☐ Pending	28a. Date of injury (Month, Day,	28b.	Time of injury	28c. Injury work	at ?		. Describe h			city)
SIO	Attend r death ctor; /	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 4 ☐ Homicide	Investigation		v - At home, fa	arm. stree		Yes 2 □ No	28f.	Location (S	treet and	Number or Ri	ural Route Number,
UIVISION	tal or rafte al Dire		4 🗆 Homicide	determined	building, etc.	(Specify)		, ,,		134	City or Tow			and reduce rearries,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2 □	Medical Exami	sician: To the best of miner: On the basis of exa se Practioner: To the b	amination and/	or investig	ation, in my opinio	n, death occurre	ed at the	time, date a	nd place,	and due to the	cause(s) and manner stated.
ĺ	Vithin Vithin Comp.		29b. Signature and title					29c. License					e signed (Mont	
			1	Z_	the			RES	-000			10	1261	2009
			30. Name and address	mi L	cuttine			EASTERN	AVENUE	: B1	ALTIM	ONE	m) 2	1224
	Stat Registra	_	31. Date filed (Month, D	2 2009	32. Registrar	s Signature		0				,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar		Cer	tificate of D	Death		Reg. No.	009	36303
	Dharainin	/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
	Physicia Medic		Charles A. Ray	Jr.				Worten	Day 8	09	17:04M
	Examin		4a. Facility Name (if not institution, give stre				Location of Death		4c. Cour	nty of Death	
			Union Memorial Hospi				ltimore	1 a B		N/A	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. It	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date 08-03-	v, Year)	9. Birthpl Counti Marv	lace (State or Foreign ry)
			Usual Residence of Decedent					1 00-03-	1737.	<u> </u>	1.4110
	sho d at	ţō	10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10	0d. Inside City Limits
	Mary 28a-f otifie	Director	Maryland N/A		E	Baltimore					1 Yes 2 No
	a or		10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Count	
	h witi ns 23 nust	Funeral	2819 Beechland Aver				21214			U.S.A	
	r iter		11. Wantai Otatas	Was Decedent Ever in U.S Armed Forces?	5. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecity Yes or No- Rican, etc.)		lace - America llack, White, e	
<u>გ</u>	within 72 hours after death with the Maryland giene ethien "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 V Yes 2 No 9- If Yes, Give 1959 – Year or Dates: 1965	1	☐ Yes 2 🔀 No	Specify:		Spec	ify: Wh	ite
9500-91212	hours natur lical E	Completed	15. Decedent's Educa	ation	16a. Deced	ent's Usual Occup	ation		16b. Kind of	Business Ind	Justry
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	5 8 E 9		Margaret A. Ray - 20a. Method of Disposition	20b. F	1 2819 Place of Dispos	Beechlan sition (Name of	<u>id Avenue</u>	Date Ba	20c. Locatio	. Mary on - City or To	land 21214 wn, State
ē	Page 1 nent of ant: If ii ary or c		1 🔀 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, cren	matory or other place Memorial	:e)				
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ñ	permit. Page 1 ar Department of H Important: If iter any injury or oth	r s	I Wales of Munes	4.	Le	eonard J.	Ruck, I		Baltimo		
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	hysician	6 0	Immediate Cause (Final disease or condition	Asustale							Onset and Death
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30	certif ending use a		23b. Was decedent pregnant	. If yes, outcome of pregna	ancy	Ectopic pregnance	01/		23d.	Date of delive	ery
. Box	death he atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Other (specify)				Month	Day Year
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Division of Vital Records,	law r has b le 2 sl	Jd m						24a. Was auto			mpletion of cause of
ř	icate r, pag		OF Mean and referred to madical					1 🗆 Yes		1 🗆 Yes	2 🗆 No
<u> </u>	siciar certif recto	Be	25. Was case referred to medical examiner? 1 Yes 24 No	pital:		Oth	lace of Death (Che				
<u>></u>	Physeral di	e: 10	27, Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	28c. Injur	y at	lome 5 Resi			
ב	ath. r. Afte e fun	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1	<br Yes 2 □ No				
18	er dez rector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	eet, factory, office		28f. Location (S		nber or Rural	Route Number,
Š	ital or urs aft ral Di lled in										
	Hosp 24 hou Fune sted fii	Medical	(Check 2 Medical Examiner	an: To the best of my know On the basis of examination	n and/or invest	tigation, in my opinio	on, death occurred	at the time, date a	and place, and	due to the cau	use(s) and manner stated.
ri	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Σ	only one) 3 L Certifying Nurse F 29b. Signature and title of certifier	ractioner: To the best of m	iy knowledge, o	29c. Licens		ace, and due to tr		manner as sta ned <i>(Month, L</i>	
	- s - ō		> S How	n mo		AT AH	38946-	BIT	Novem	her &	2009
			30. Name and address of person who corn		n 23a) (Type, F				100000	ypar U	, 2007
			Sara Harareaves	201 E. Uni	iersity -	Parkwan	, Balti	more	MD	21218	
	Sta		31. Date filed (Month, Day, Year)	g 32. legistrar's Signa		arkel					
	Registr	-16	MAN CARA	- Marie -	1 (1						

36304 State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 November 9, LORRINE M. RANDLE 3:25 P 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth (Month Day Year) Aug 12, 1929 f Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days 1 □ M 2 🖺 F Maryland 80 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 X Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 21225 603 Washburn Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐Yes 2 X No White Specify: 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Mother Momemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George W. Sauers Georgia Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Georgia K. Sabol (Daughter) 6 West Fifteenth Ave., Baltimore, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225—1856 21. Signature of Funeral Service Licensee Kevin E Ecker Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): vn

Physician /Medical Examiner Examiner For State Registrar

5. Social Security Number

218-26-3769

10e. Street and Number

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

30. Name and address of person who s

31. Date filed (Month, Day, Year)

11. Marital Status

10a State Maryland

Director

Funeral

Be Completed by

9

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Examinar must be multilised at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran Physician/Medical s been signed by the should be detached Completed by his certificate has I director, page 2 s Be Certification: To this After thi hours after death. within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	l				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions col	ntributing to death but not resu	ulting in the underlying	g cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death? 2
	a+			24a. Was an autopsy performed	
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 patient 2	ER/Outpatient 3 □	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 ☐ Other (Specify)
27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how i	injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	sician: To the best of my kno ner: On the basis of examina and manner stated.				se(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifiar	7 1		29c. License number	29d.	Date signed (Month, Day, Year)

State Registrar

Medical



pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Discretify New State				For State Registrar	St	ate of Ma	arylan	d / Dep Ce	ertificate of L	ieaitr Death	n and	Mental Hy	gien Reg. N		36	305
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9 36306 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 2009 Year HERBERT ROCHLIN 5:08 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Months Days Hours 08-07-1933 218-28-4163 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State within 72 hours after death with the Maryland 10d. Inside City Limits must be notified at Funeral Director MD 28a-f BALTIMORE BALTIMORE 1 🗆 Yes 2 🗶 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? 23a 7705 CROSSLAND ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. P Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced WHITE Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) PARTNER BURGER KING RESTAURANTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ **JACK** ROCHLIN SARA LEVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau SHARON ROCHLIN/WIFE 7705 CROSSLAND ROAD, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, OWINGS MILLS. HAR SINAT 11-08-2009 Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. Matt 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dicreatic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar 29a. Certifier

29b. Signatule and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

softour

3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH C897 department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** loven her-/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner UN est 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** 219-58-1964 1**X** M 2□ F Months Days Min. Yrs (00) 24,1948 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evantment in ust be a differ a proper any injury or other traumatic event, If a Medical Evantment is ust be a differed any once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 □ No by Funeral Director YOU 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1506 3130 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Mever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 18. Mother's Name (First, Middle, Maiden Surname) ∨ № K 17. Father's Name (First, Middle, Last) UNK Be P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nanc) Rose-Kos 3705 Niner Rd Finksbure MIL) 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Femation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) nemortaly 11-12-09 21. Signature of uneral Service Licens 22. Name and Address of Facility Approximate Interval Between Onset and Death 1232 Movalle of the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. 23a, Part 1 shock, or Immediate stuse (Final disease or condition resulting in death) **Physician** Ances /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) Pregnant at time of death 1 ☐Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only oge)

Other:

4 ☐ Nursing Home 5 ☐ Residence HOSPIEE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 MOthe Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Territying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NNV 12 2009 32. Registrar's Sid State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 36308 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician November 10,2009 JOHN WILLIAM SPURRIER 11:05A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. NOV 26, 1920 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral X**XM 2□ F Mary Tand 215-18-5164 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Tyglene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show amy injury or other traumatic eve It, the Medical Examination and once. 10b. County 1 ☐Yes ¾√XNo Director Berlin Maryland | Worcester Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11506 Country Club Drive 21811 USA Completed by Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married XX Married 1 □Yes XX No If Yes, Give Year or Dates: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) United States Marshall Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter David Spurrier Anna Malone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 11506 Country Club Drive Berlin Maryland 21811 Jacqueline Wagner Spurrier Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery Nov 13,2009 Baltimore, Maryland Donation 5 ☐ Other (Specify) nature of Funeral S wice License 22. Name and Address of FMMTCHELL-WIEDEFELD FUNERAL HOME INC 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** cause the substitution of Examiner Due to (or as a consequence of) Physician/Medical for use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 ☐ Other (specify) o. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an 2 100 2 No 1 □ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1No Medical Certification: To 1 ☐ Yes 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 Compying Mysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) DS3612 11/10/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Baier MD 9733 Healthway Drive Berlin Maryland 21811 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 1 2 2009 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 20 36309 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sparkman Mary Month **Physician** 200 toper /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ounty of Deat Examiner 8. Date of Birth (Month, Day, Year) 10.08.1931 6. Sex 9. Birthplace (State or Foreign **Funeral** Country) N.C. 1 M 2 KF Months Davs 242.40.5088 78 Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f sh edical Examiner must be notified es 2 No Director MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21202 10 N. Calvert Street U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Specify:White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4. Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. J other than " event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Technician Pharmacutical 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Laura E. Daniel Lethro Roy Benson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardie Shaw/Legal Guardian 344 Hickory Point Rd. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 ☐ Burial 2 Fremation 3 ☐ Removal from State Chesapeake Crem. 10.20.09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA W01443 8717 Green Pastures Dr. Balto., MD 21286 23a. Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2000min /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influentate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine stone physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pege 2 should be Jones 1 | Yes 2 | No 3 | Probably 4 | Yonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 21400 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

or Attending Physician;

Hospital

within 24

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV TS SOON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

SHOAIIS A. HOS KMIMD & 21 N. ENTAWST Sinte 308, BALTIMORE MD

barker

MD

32. Registrar's Signature

29c. License number

DZIYLY

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Berdella Rhodes Saunders "3 2009 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number N/A Huspita if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/02/1924 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 X F 214-20-4747 85 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examinant must be notified at Director 1XYes 2 No MD N/A Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 1106 Lyndhurst Street 21229 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced 'natural', Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Baltimore City Crossing Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aaron Rhodes Irene Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Saunders Jr. (son) 3610 Copley Rd., Baltimore, MD 21215 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cometer), crematory or other place)
JOSEPH Brown F/H
And Cremation 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/11/09 |Baltimore,MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Baltimore, MD Whamo 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) Thirty minutes /Medical Due to (or as consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examine if any leading to terminate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed burial-transi and Due to (or as a consequence of) P.O. Box 68760; attending physician for use as the burial requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☑ No Month Year ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ģ signed } Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, icate has been si r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 400 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) he Hospital or Attending Pl n 24 hours after death. he Funeral Director: After the pletely filled in by the funeral 27. Manner Jeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Hatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) w 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) MO Baltmore 900 South Coton Avenue Manylan Haltown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Registrar

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			Registrar 1. Decedent's Name (First, Middle, Last)		,		Reg. I	40.	3. Time of Death
	Physicia		Calvin	57	EPP		October.	31, 2009	1858 PM
	/Medic Examin		4a. Facility Name (If not institution, give street			Location of Death	-	4c. County of Deatl	h
K.			Johns Hopkins Bay 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	ev Baltim	If Under 24 Hrs.	8. Date of Birth	Baltim	hplace (State or Foreign
	Funeral Director		215-17-8245 10M		rrs. Months Days	Hours Min.	Month, Day, Yea	1986 00	Maryland
	D D		Usual Residence of Decedent	140.00		11	o sure dej		10d. Inside City Limits
	naryiar F show	ō	Maylard 10b. County	10c. City, Town	Bay	Himore			1 Dres 2 No
	me n 28a-	irect	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	un y ry?
:	23a ol	ral D	920 Myrtle Ar	e.	ó	21201		W	4
o :	is 1 and 2 should be lineo within 72 hours after death with rhe maryland if Health and Menhall Hygione. Hear 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination in critical and other traumatic event, the Medical Examination is critical and other traumatic event, the Medical Examination is critical and other traumatic event, the Medical Examination is critical and other traumatic event, the Medical Examination is critical and other traumatic event, the Medical Examination is critical and other traumatic event, the Medical Examination is critical and other traumatic event, the Medical Examination is critical and other traumatic events.	Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of H	ın, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
	ural", o	d by		If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: B G	CF
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2 3	id 2 sr lith an 27 is r r traur		19a. Informant's Name/Relationship (Type.	- nother 9:	20 My H	AIM.	Ballimore	Maryla	(- d
ນ໌.	of Hear		20a. Method of Disposition	cometon	Disposition (Name of crematory or other place	e) /	Date 20c.	Location - City or	Town, State
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ם	permit. Fagges 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item once.		21. Signature of Funeral Service Licensee	arker	22. Name and Address	s of Facility far enck A	Kerfune ve. Ballin	ral Home	4.A. 21229 Heland
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complete the complete shock is the complete shock of the complete shock.	ons that caused the death. Do no	ot enter the mode of dyin	g, such as cardiac	or respiratory arrest,	/	Approximate Interval Between Onset and Death
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ַ נַ	nas be	Completed	Sepsis, Seizu	ive disorder			24a. Was an autopsy	prior to e	utopsy findings available completion of cause of
	icate l	S		154			performed 1 Yes 2 □	? death? No 1 ☐ Yes	2 No
V IE	certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hosp	ital:	Other	ar.	th (Check only one)	0.000	
5	erthis eral di	n: To	27. Manner of Death	Para Date of Para 2 ☐ ER/Out 28a. Date of Para 28b. To	ime of 28c. Injur	y at	ome 5 Residence 28d. Describe how in	1-7	city)
	or: Aff	atio	1 Avatural 5 Pending investigation	(Month, Day, Year) In	jury Work M 1 □	Yes 2 □No			
	after de Directe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home, fare building, etc. (Specify)	m, street, factory, office		28f. Location (Street City or Town, St	and Number or Ruate)	ural Route Number,
Locales	within 24 hours after death. To the Furneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C		an: To the best of my knowledge, On the basis of examination and and manner stated.					
4	Within Compl	Me	29b. Signature and title of certifier		29c. Licens			Date signed (Mont	
) WROZ		Do	438	3 00	tober o	31, 2009
			30. Name and address of person who compl		Type, Print)	5 Hopi	Line Ba	701000	c-wele_
	Sta	te	31. Date filed (Month, Day, Year)		barke	1 The Mie	100	1 2-2-2	•
	Registr		NOV 1 2 2009	Chown B.	49 400				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36313 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Viola Bertha Steiner 18:32 M 2009 Medical 4a. Facility Name (if not institution, give street and number)
Good Samasitan Ho Examiner 4b. City, Town, or Location of Death 4c. County of Death altimose . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Min 06^M170, ^D1922 213-14-8729 Yrs **Director** Maryland Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3610 Keene Avenue 21214 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify. 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mollie Wolf Phillip Moll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3610 Keene Avenue Baltimore, Maryland 21214 Phyllis A. Steiner - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 11-13-2009 Baltimore, Maryland 21. Sign tuneral Service 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) Medical Due to (or as a consequent of): **Examiner** neumoni Sequentially list conditions if any leading long reduc-cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ ☐ Unknown in the past 12 months? Month Day Year 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Effusion, Sick Sinus Syndrome, 1 Yes 2 No 3 Probably 4 Unknown , Acute Renal Failure, Acute Tubular Necrosi's 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy Metabolic Acidoci's Themia performed 1 Yes & No rs after dean: ral Director: After this cerus. Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29b. Signature and title of certifier 09 MD RESOOO

Registrar DHMH 17 Rev 7/2009

State

CAROLINE

31. Date filed (Month, Day, Year)

LOCHRAVEN BLUD,

BALTIMORE, MD-21239

5601

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DISOUZA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36314 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 07 2009 12:43 рм Stankovich Georgine Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Stella Maris Timon<u>ium</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min Director Mary land 219-07-5443 87 Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Baltimore <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7224 Bay Front Road 21219 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 12:43 р.ш. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 If Yes Give 1 ☐ Yes 2 🙀 No Specify. Specify. 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within 8 <u>Home Maker</u> Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Orlik Stanlev Marie Juszczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7224 Bay Front Road, Baltimore, MD 21219 Joanne Stankovic, Daughter NOVEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 11/11/2009 Baltimore, Maryland Holv Redeemer Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or imjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2X No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STANKOVICE 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 24 hours after death. Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) GEORGINE Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 $\overline{\mathbf{X}}$ Other (Specify) **HOSPTCE** ပု 1 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1X Natural 5 Pending work? 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD

32. Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygien 9 1 9 36315 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month STRAUSS **Physician** GEORGE Hovember 2009 106 p.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 15, 19 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**□M 2□F Months 89 Yrs Director 214-12-2186 Usuel Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23e or 28a-f show any injury or other treumatic event, the Modical Examinating and page. 10c. City. Town or Location 10a State 10b. County 1 Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR619 21228 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married Married Specify: White 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Underground Utilities 8 Utility Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George A. Strauss, Sr. ပ္ Beulah Hetrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dina T. Strauss (Spouse) 719 Maiden Choice Lane, Catonsville, MD 21228 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 11/11/09 Finksburg, MD Mod764 HAIGHT FUNERAL HOME & CHAPEL, PPO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee Blian HUN 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. physicien Physician/Medicai the use as t ed by the attending r deteched for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Colona heral 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physicien: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient 2 ER/Outpatient Certification: To 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending death. 2 Accident investigation 1 TYes 2 TNo within 24 hours after deat To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation in my existing death account of the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar Rangerago

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hamswany

31. Date filed (Month, Day, Year)
NOV 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 4551E NICHAEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Nov. 28, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ^{Year)} 1926 **Funeral** Months Days Hours Min. New York 1**X**) M 2□ F 066-22-0821 82 Nov. Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Prodical Examinar must be notified at New York Queens Flushing 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41-10 Bowne Street 11355 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2∰No Specify White ģ If Yes, Give Year or Dates: WWII Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant NYC Human Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Menta tem 27 is marked Michael Sassie Christina Weckesser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Hirschberg, Nephew 6372 Burnt Mountain Path, Columbia, MD 21045 Pages 1 gment of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery | 11/13/2009 | Maspeth, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuseral Service Licensee 22. Name and Address of Facility Frederick Funeral Home, Inc. T. Harman 184 192-15 Northern Blvd., Flushing, NY 11358 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): Examiner doninal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year)

State Registrar

State 31. Date filed (Month, Day, Year) strar 400 1 2 200



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Ī	Funeral Director		5. Social Security Number 6. S 217-05-8478	· \$77 · · · · · · · · ·	(In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Dec. 30	Year)	9. Birti 20 Mar	hplace (State or Foreign untry) yland
	rland F show d at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov							10d. Inside City Limits
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2-0030	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates.	No		Yes, specify Cuba	Specify:	Hican, etc.)	s	Black, White Specify: Wh	e, etc. nite
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Vear RUTH A. SNYDER 09:26AM November, 07 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON or 1 Year | If Under 24 Hrs. If Under 1 Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 M 2 XF 86 Director 219-20-5981 7/31/1923 PENNSYLVANIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE PARKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code by Funeral 7906 HILLENDALE ROAD USA 14. Race - American Indian, 21234 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 💢 No Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12TH GRADE OWN HOME and Mental Hygi Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Pages 1 and 2 should be JOHN WESLEY FRYE ELIZA ORNDORFF traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If Item 27 Is any injury or other trau KENNETH R. SNYDER, JR./SON 2030 FALLSGROVE WAY FALLSTON. MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State PARKWOOD CEMETERY 11/11/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee MO1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. moson 8521 LOCH RAVEN BLVD. TOWSON. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PSIC (Pas a consequence of): Se day disease or condition resulting in death) /Medical Due to (Obstruction Examiner Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Yes 2 No the a∏lJnknown 9 Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 **X**No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? /es 2 No certificate Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ō this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Director: After 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Year) State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of I	Marylar		artment of H		d Mental Hy	giene Reg. No. 7	000	2.0	000
			Decedent's Name (First, Middle, III)		2. Date of De	ath	009	3. Time o	Dealin U				
	Physici /Medio		Patri	cia J.	Sto	W			Novemb	er 5,	2009	4:50	АМ
STA.	Examir		4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town, o	r Location of D	eath	4c. Cour	nty of Death		
			Suburban Hospit				Bethe		Hen La B : (B)		ntgome		
	Funeral Director		5. Social Security Number 6 010-34-5961	. Sex 7. 1 □ M 2 🛣 F	Age (In yrs. 63	last birthday) Yrs.	Months Days		Hrs. 8. Date of Bir Min. (Month, Da April 26	v Year)	Cour	olace (State on otry) achuse	
	D		Usual Residence of Decedent						740111 20	, 1540	11455	aciiuse	
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	he Me	Director	Maryland Montg	omery	ļ.	Potoma							2⊠No
	with t	Ρ̈́	10e. Street and Number 14005 Gorky Dri	W.A			10f. Zip Code)854		10g. Citizen o	ed Sta		
	ms 2%	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.			(Specify Yes or No uerto Rican, etc.)		ace - Americ		
21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evartiner must be rediffed at	by	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	X) No		fYes, specify Cuba 1 □Yes 2X No	Specify:	uerto Rican, etc.)	Spec	lack, White, e	etc. ite	
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121	vithin	mpl	Elementary/Secondary (0-12)	College (1-40	or 5+)	life.	DO NOT use retired	1)	vorung	D 1			
20	filed v Hygid Hygid Wither 1		17. Father's Name (First, Middle, La	st)		Denta	1 Technic		Name (First, Middle		tistry _{ame)}		
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ary	shou and N s mar		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street		r Rural Route Numb	er, City or Tow	ın, State, Zip	Code)	
	5 6 7 F		Robert C. Stow /	Husband					otomac, M	aryland	1 2085	4	
altimore,	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3	☐ Removal from Sta	te 20b. F	Place of Dispo cemetery, crei	sition (Name of natory or other plac	e) Nov	. To,	20c. Location	-		
	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Spe		Mont	<u> </u>	Crematorium	· '	009	Bethes			nd ————
Ba	permit. Pages 1 a Department of He Important: If item any injury or othe		21. Signature of Funeral Service Lic	a W	м01	305 Rc 30	bert A. Pur West Mont	nphrey Fu gomery A	meral Home/ wenue, Rock	Rockvill	le, Inc aryl <i>a</i> nd	20850-	-2805
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8760,	be exectan a	E	resulting in death) Last	Due to (or	as a conseq	uence of):							
	physicate the t	dical		d									
Box 6	attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna	ancy				234 [Date of delive	arv	
m	death e atte d for t	icia	in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birt 4 ☐ Pregnan	t at time of o		Ectopic pregnanc Other (specify)	y 			vionth		Year
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eco	e law requii has been s je 2 should	Completed							24a. Was	an 24t	o. Were auto	psy findings	available
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o	di is	<u>د</u>	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 X Inpa		ER/Outpatier 28b. Time of		4 🗆 14015111	g Home 5 Resi			y)	
on :	Attending ir death. ector: After by the fune	tion	1 X Natural 5 □ Pending 2 □ Accident investigati	(Month,	Day, Year)	Injury	Worl	yan (? Yes 2∐No	Zou. Describe	low injury occi	urrea		
visi	Atter	Certification: To	3 Suicide 6 Could not	he -	Injury - At ho	ome, farm, str	eet, factory, office		28f. Location (nber or Rura	l Route Nun	nber,
Ö .	rs after or rs after al Dir ed in	Cert	4 Homicide	building,	etc. (Specii	у)			City or To	vn, State)			10
	ro the rospital or Attending Fri within 24 hours after death To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 ★ Certifying 2 ★ Medical Ex	Physician: To the be aminer: On the basis and manner	s of examina	wledge, deatl ation and/or in	n occurred at the tirvestigation, in my o	ne, date and pl pinion, death o	lace, and due to the occurred at the time,	cause(s) and date and place	manner as s e, and due to	tated. the cause(s	5)
	vithii To th	Me	29b. Signature and title of certifier	16.000	10	16)	29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)	
			Deserting M	. Haygur	y		D32	407		Novemb	er 5,	2009	
			30. Name and address of person wh	•	•			Day day	Doc1	0 M =	-1 cm -1	20850	
	Sta	e.	Joseph M. Hagger 31. Date filed (Month, Day, Year)		9/U/ strar's Signa		1 Center	prive,	Rockvill	e, mary	утапа		
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36321 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Clifford 2009 Ε. Smith 9:48 РМ November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min September 21,1923 New York Director 063-18-3596 86 Usual Residence of Decedent f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11001 Huntover Drive 20852 United States items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' 0 Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White "natural", WWII 3 X Widowed 4 Divorced Specify Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineering Engineer 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Everest Smith Ethel Haynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, E.C. Yegen, Jr. / Son-in-law 11001 Huntover Drive, Rockville, Maryland 20852 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of F cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State November 9, Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Rapu Patter M01305 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Heart Failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Pneumonia as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hypotension IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be History of Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 X No certificate l 1 Yes 2 No Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA of completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 🛚 Natural injury 5 Pending Division Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D Medical 29a, Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gardiying Nursu Fractioner: To the College of the College of the time, date and place, and due to the cause(s) and manner as stated. (Check only una) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 65312 11 6/04 MI) 30. Name and adgress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Sudarshan Siva,

31. Date filed (Month, Day, Year)

M.D.

32. Ra istrar's Signature

8600 Old Georgetown Road, Bethesda, Maryland 20814

Amend Item 200 per 111, 1897, Perastrong of Health and Mental Hygiene 2009 36322 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PHILOMENA MARY SALVETTI NOV. 06, 2009 11:55 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3408 ELLIOTT STREET N/A BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. OCT, 213-10-9965 95 Director 1, 1914 MD. Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Madical Evantinat is use to notified at 1 ☐ Yes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or any hiury or other traumatic event, the Madical Evantiant rough ben any hiury or other traumatic event, the Madical Evantiant rough ben and bone. 321 IMLA STREET 21224 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates Specify: WHITE \$ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8TH 0 SEAMSTRESS TAILORING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANCIS CONCORDIA ADELINA MINGERELLI ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK SALVETTI/SON 3408 ELLIOTT STREET, BALTIMORE, MARYLAND 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/10/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 11/10/00 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) Signative of June al Service Licensee CHARLES S. ZEILER & SON, INC. 6224 EASTERN BALTIMORE AVE., Approximate Interval Between Onset and Death Parth. En er to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, HYPERTEN Immediate Carse Final **Physician** ENCEPHAL MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown iis certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD ST 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 1 2 2009 Registrar

DHMH 17 Rev 1/2001

			1 Decedent's Name (First Middle Last)	Pate of Death	Reg. No.				
· ·	Physici /Medic		James Sle	bzak Novemi	oer 7, 2009 10:15PM				
A. A.	Examin	er	The Johns Hopkins Hospital Ba	City, Town, or Location of Death	4c. County of Death				
	Funeral Director			hder 1 Year If Under 24 Hrs. ths Days Hours Min. 8. Date of Bir (Month, De 4 - 28 -	ay, Year) Country)				
	Maryland a-f show ied at	I Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD BALTIMORE	ROSEDALE	10d. Inside City Limits 1 ☐ Yes 2 🛣 No				
	death with the Marylan ms 23a or 28a-f show must be notified at		10e. Street and Number 1503 BRIAN ROAD	Zip-Code 21237	10g. Citizen of What Country? U.S.A.				
36	hours after death with the Maryland ural", or Items 23a or 28a-f show I Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 1 Never Married 2 Narried 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married	lecedent of Hispanic Origin? (Specify Yes or No specify Cuban, Mexican, Puerto Rican, etc.) es 2 √ No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE				
1215-0036	be filed within 72 hours after dea ital Hygiene. ed other than "natural", or items event, the Medical Examiner mu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12. 15. Decedent's Education (Give kind of life. DO NO 12. 16a. Decedent's (Give kind of life. DO NO 186. 17. 18. Decedent's Education 18. Decedent's Education 18. Decedent's Education 18. Decedent's Education 19. Decedent's	Usual Occupation If work done during most of working Of use retired) & SAFTEY REP.	16b. Kind of Business/Industry SOCIAL SECURITY ADMINISTRATION				
and 5	should be filed id Mental Hygi marked other matic event, tt	To Be C	JAMES B. SLEBZAK, SR	18. Mother's Name (First, Middle					
Maryland	d2s h ar 7 is trau	. 10	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Add	dress (Street and Number or Rural Route Numb BRIAN ROAD ROSED	per, City or Town, State, Zip Code) OALE, MD 21237				
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, crematory ST. STANIS	(Name of or other place) LAUS CEM 11-12-09	20c. Location - City or Town, State DUNDALK, MD				
Balti	permit. Pag Department Important: any injury once.			· · · · · · · · · · · · · · · · · · ·	SEDALE FUNERAL HOME SEDALE, MD 21237				
)	Physician /Medical	y 0	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	mode of dying, such as cardiac or respiratory a Hemorrhage	rrest, Approximate Interval Between Onset and Death				
,	ficate be executed physician and as the burial-transit	ш		·					
	certificate be iding physicia use as the bu	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy						
о. Бох	the death of the attenor ched for u	nysiciar	23b. Was decedent pregnant in the past 12 months? 1	oic pregnancy r (specify)	23d. Date of delivery Month Day Year				
cords, P.	law requires that the death certi as been signed by the attending s 2 should be detached for use a	Completed by Ph	ran in Other significant conditions continuing to death but not resulting in the underly	ving cause given in Part I. 23e. Did t	obacco use contribute to the cause of death? Yes 2 ☐ No 3 Probably 4 ☐ Unknown				
	The lay the has bage 2			24a. Was autop perfo					
ı vıtalı	Physician: The this certificate ral director, pa	To Be		26. Place of Death (Check only on DoA Other: 4 Nursing Home 5 Resid					
Sion of	nding Phath. ath. : After thi ie funeral			28c. Injury at Work? 1 Yes 2 No	now injury occurred				
בוביי	or the Hospital or Attending Physician; within 24 hours after death To the Funeral Director. After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	e Hospit 24 hour e Funere			rred at the time, date and place, and due to the ation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)				
)	To the within comp	Me	29b. Signature and title of certifier	RES-000	29d. Date signed (Month, Day, Year) Vovember 7, 2009				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		olfe St, Baltimore, MD, 21287				
i	Sta Registra	.e	31. Date filed (Month, Day, Year) 22. Registrar's Signature.	?					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36324 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Santoni 7:27 AM Μ. November 10, 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 214-01-7224 Aug 13. 1911 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300-F Hazelnut Court 21015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ★Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Matarazzo Marv Eaitto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Santoni-son 9524 Grand Estates Way, Boca Raton, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 11/13/09 4 ☐ Donation 5 ☐ Other (Specify) Overlea, MD 21. Signature of Funeral Service Censee William G. Dau Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Completed

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Physician/Medical

Be Completed by

Medical Certification: To

31. Date filed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Eventination in the confidured at

attending physician a for use as the burialsigned by I Hospital or Attending

antoni, Mary M80051820

disease or condition resulting in death) Sequentially list conditions, if a y, leading to manediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of):	>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 monts? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy eer (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ying cause given in Part I.		o use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Onknown		
CAD			24a. Was an autopsy performed? 1 □ Yes 2 □	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)			
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hom	ne 5 🗌 Residence	6 ☐ Other (Specify)		
27. Manner of Death 1		Work?	8d. Describe how in	jury occurred		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	8f. Location (Street City or Town, Sta	et and Number or Rural Route Number, State)		
29a. Certifier 1	nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investion and manner stated.	curred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)		
29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)		
		100	Λ 1	1 1.00		

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 36325 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 707 PM Altred C Stepowanu 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltanose Medical N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 125M 2□F 53-20-964 81 Director 10,1928 April New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 Is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director Maryland N/A <u>Baltimore</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1900 Thames Street, Apt. 408 21231 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Representative <u>Electrical</u> 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ဥ Albin Stepowany Magda <u>Vengen</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 19a. Informant's Name/Relationship (Type. Print) Apt 408 Date Department of Health Important: If Item 27 any injury or other trong. MAry Ellen Stepowany 1900 Thames Street, Baltimore, Maryland 20b. Place of Disposition (Name of cametery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, Sta 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Haney valley Memorial Gardens 4 Donation 5 Nother (Speritombment 11-10-2009 Timonium Maryland Ruck Towson Funeral Hom 22. Name and Address of Facility ure of Eugeral Service Licensee 1050 York Road 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician www /Medical Due to (or as a consequance of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and stranger the burial-tranger Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2MNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: / t in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hours aft le Funeral Di lletely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NP1 1881852325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mercy Memical Center Buss Paul Plcae Baltimore, Maryland 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 36326 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 15 Wich /Medical 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8800 WALTHER BLVD., #4508 PARKVILLE f Under 1 Year | If Under 24 Hrs. BALTIMORE 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min 054-18-6813 Director 85 04-30-1924 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show epartment of Health and Mental Hygiene.
mportant: if tem 27 is marked other than "natural", or items 23a or 28a-f show
ny injury or other traumatic event, the Medical Examinar must be notified. Director MD BALTIMORE 1 ☐ Yes 2 X No PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8800 WALTHER BLVD., #4508 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT 4 ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL SILVER JANE AVIDON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BENJAMIN SCHEININ/HUSBAND 8800 WALTHER BLVD., #4508, PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Buria J 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) LUBAWITZ NUSACH ARI 11-11-2009 | BALTIMORE, MD Funeral Service Lens 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one conse on Immediate Cause (Final **Physician** disease or condition /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off requires that the death certificate be executed nding physician ause as the burial Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the O. 9 I Unknown 9 Unknown ۵. signed | nditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed certificate of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home Certification: To 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending atural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

8800

win

2. Registrar's Signature

Rose Lea Salzman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 36327

		1- For State Registrar			C	ertifica	ate of	Death	<u> </u>				eg. No.		0)	0002
Physicia ledical Exami	n/	1. Decedent's Name (First, N	nt's Name (First, Middle,Last) LEA SALZMAN										th Day r 7, 2009	Year		ne of Death 30 hrs
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		104 Ewing Drive	ution, give sti	ect and no	nber)				erstown				Balt	imore Co	ounty	
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs	. last birtl	nday)		r 1 Year	If Under		. Date of Bi	rth(MM/DD/	YYYY) 9. E Fore		(State or
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AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medic I Examiner must be notified at once	ם	19a. Informant's Name/Rela							(Street	and Numb			ımber, City o	or Town, Sta	ate, Zip C	Code)
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			1 – For State Registrar	State of Marylar		artment of F		_	ene2009	36328
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	Examir		4a. Facility Name (If not institution, give s	reet and number)	morc		r Location of Death	/-/	4c. County of Deal	h
	Funeral Director	П	5. Social Security Number 068 - 14 - 9995 6. Sex	7. Age (In yrs. 9	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/31/1	(ear) 9. Biri	hplace (State or Foreign untry)
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
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	Attending Priy r death. ector: After this by the funeral di	ation:	27. Manner of Death 1 ★ Natural 5 ☐ Pending 2 ★ Accident Investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	yat <br Yes 2 □No	28d. Describe how	injury occurred	
	after deg after deg Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office	1	28f. Location (Stre City or Town, S	et and Number or Ru State)	ral Route Number,
		Medical C	29a. Certifier Certifying Physic (Check only one)	cian: To the best of my knoer: On the basis of examina	wledge, death tion and/or inv	occurred at the tirvestigation, in my o	me, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	s stated. to the cause(s)
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•			30. Name and address of person who com	pleted cause of death (Item	n 23a) (Type, F	Print)	943	1	1/09/09	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36329 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November Year 2009 Physician/ 0550 H M loyd Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner By Honore Bayview Medical Conter Johns Hapkins If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Hours 11-30-1945 63 MD Director 212-46-1725 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director Yes 2 No BALTIMORE TURNER STATION MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Funeral items 23a 21222 IISA 105 WALNUT AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than should be filed within and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MAINTENACE 12 PARKS & RECREATION permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ WILBERT THOMAS, SR. EMMA JEAN COLEMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) BALTIMORE, MD 21222 105 WALNUT AVE. RAMONA THOMAS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11-11-09 BALTIMORE, MD METRO CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signate e of Funeral Service Licenses 21217 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Hepatonenal s

Due to (or as a consequence of): Physician/ Medical resulting in death) Examiner colon iV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown 1 ☐ Yes 2 L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Yes 2 LHNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatle Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 10058873 November 2009

Registrar
DHMH 17 Rev 7/2009

State

1. Browner, MD

31. Date filed (Month, Day, Year)

Eastern Avenue

32. Registrar's Signature

MD

Raltemore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

2 2009

			State of Maryland / Departm State Amend Items 23a PtI, per dr., go Certific	7,19f/12709and Nate of Death	fental Hyg R	iene 2009 36330
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	ysicia Viedica		Sam Taylor		Septemb	er 27, 2009 7:50 PM
Ex	amine	er		City, Town, or Location of Death		4c. County of Death
				ethesda nder 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign
Dire	eral ctor		424-80-9185 1 N 2 F 52 Yrs. Mon		(Month, Day, Sept 26	Year) 1957 AL
pu ,			Usual Residence of Decedent			
arylaı show	100	٦ ا	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1√1 Yes 2 □ No
the M 28a-f	di li	Director	MD Montgomery Silver Sprin 10e. Street and Number 10f	. Zip Code	11	Dg. Citizen of What Country?
with 3a or	I be		1574 Ivy Stone Court	20904		USA
-UU36 hours after death with the Maryland tural", or items 23a or 28a-1 show	E	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
after or ite	ale i		1 Never Married 2 Married 1 Yes 21X No	specify Cuban, Mexican, Puerto s 21 No Specify:	Hican, etc.)	Black, White, etc.
Z1Z15-0036 3 within 72 hours aff giene.	E :	g p	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: Black
13-7 n 72 n	led led	Completed	life DO NO	Usual Occupation f work done during most of worki T use retired)	ing	16b. Kind of Business/Industry
y with giene.	The	Ē	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Parale	,		Legal
// // // // // // // // // // // // //	e l	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N	faiden Surname)
Aarylan 2 should be and Menta Is marked	affice	0	Jack Taylor, Sr.	Lulu Woo	odruff	
Mar d 2 sho lith and 27 is m	traum	1		ress (Street and Number or Rura er Road Apt. i		
1 and Heall tem 2	other	1				20c. Location - City or Town, State
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked	y or c		20a. Method of Disposition W☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition of cemetery, crematory St. Matthews			Davton, AL
altill mit. F partm portar	in ei	ł		e and Address of Facility ulia White Fund	1	, ,
n aae	e d			.0. Box 1332		
			3a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the snock, or heart failure. List only one cause on each line. Asystole	mode of dying, such as cardiac	or respiratory arre	Interval Between
Physic	_		Immediate Cause (Final disease or condition resulting in death)	est		Onset and Death
/ /Med Exami	_		Due to (or as a consequence of):	conary Artery D	isease	
			Sequentially list conditions, b. Due to (or as a consequence of):	CITICAL OCT	147	minuics
cuted	ansit	Examiner	Tank leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
e exe	rial-tr	Ĭ	resulting in death) Last Due to (or as a consequence of):			777
icate be executed physician and	the bi	alcal	d			
VISION OF VILCE THE COLOS, F.O. DOX Of Attending Physician: The law requires that the death certificate has been signed by the attending ector: After this certificate has been signed by the attending	se as	rnysician/me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Data of delivery
death cer attendir	d for u	Clar	in the past 12 menths?	oic pregnancy r (specify)		23d. Date of delivery Month Day Year
t the c	achec	<u> </u>	1 Yes 2 No 9 Unknown 9 Unknown 5 Other			
es tha	e det	5	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
law requires t as been sign	appino 1				1 □ Ye	s 2 No 3 Probably 4 Unknown
law law l	e 2 sh	completed			24a. Was ar autops	prior to completion of cause of
The :: The	, pag				perform 1 □ Yes 2	ned? death? MNo 1 □ Yes 2 □ No
VILAI sician: 1 s certifica	irecto	۵	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Immediate 2 ☐ FR/Outpatient 3 ☐	26. Place of Death		
er this	eral dir	1	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	me 5 \(\) Reside 28d. Describe ho	nce 6 Other (Specify) w injury occurred
ending ath.	e fun	9	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation M	Work? 1 ☐ Yes 2 ☐ No		
	₹ 1.9		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	tory, office	28f. Location (Str City or Town	eet and Number or Rural Route Number, State)
r Att	<u> </u>					
DIVIS oital or Att urs after de eral Directe	illed in by the funera				and due to the co	ause(s) and manner as stated.
e Hospital or Att	oletely filled in by		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investiga and manner stated.	red at the time, date and place, tion, in my opinion, death occurr	red at the time, da	ite and place, and due to the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director: After this certificate has been signed by the attending	completely filled in by	enical	(Check only 2 ☐ Medical Examiner: On the basis of examination and/or investiga	tion, in my opinion, death occurr 29c. License number	red at the time, da	and place, and due to the cause(s) and Date signed (Month, Day, Year)
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft	completely filled in by	enical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	tion, in my opinion, death occurr	red at the time, da	ite and place, and due to the cause(s)
To the Hospital or Att within 24 hours after de	completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investiga and manner stated. 29b. Signature and title of certifier On the basis of examination and/or investiga and manner stated.	tion, in my opinion, death occurr 29c. License number 68374	L 29	ate and place, and due to the cause(s) ad. Date signed (Month, Day, Year) 9/27/09
To the Hospital or Att within 24 hours after de To the Funeral Direct	completely filled in by	ואפתוכם	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated. 29b. Signature and title of certifier Amelical Examiner: On the basis of examination and/or investigated and manner stated.	tion, in my opinion, death occurr 29c. License number	L 29	ate and place, and due to the cause(s) ad. Date signed (Month, Day, Year) 9/27/09

			For State Registrar	tate of Maryland	l / Depa <i>Cer</i>	artment of F <i>tificate of D</i>	lealth and I Death	Mental Hy	giene 2009	9 36331
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of De	4.4L	Time of Death
,	Medic	cal	Mark 4a. Facility Name (if not institution, give street	G. Tennyso	n			Novemb		
	Examin	ier	6320 Haviland Drive	and number)		Bethes	Location of Death		4c. County of Dea	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days		8. Date of Bir	th 0 Bi	irthniace (State or Foreign
	Director		579-46-2759	² 77	Yrs.			February	15, 1932 Wash	nington, D.C.
	f shov	ţoţ	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	r 28a- notifie	Direc	Maryland Montgomer 10e. Street and Number	y Bet	hesda				100	1 ☐ Yes 2 🕅 No
4	with the	Funeral Director	6320 Haviland Drive			10f. Zip Code 2081	7		10g. Citizen of What C	•
40	items items her mu		11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. W	vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,
336	al", or	d by	1 Never Married 2 X Married	X Yes 2 □ No Yes, Give Korean		☐ Yes 2 🔀 No		Tiloan, etc.,	Black, Whi Specify: Wh	
2-0	nours natura dical E	Completed	15. Decedent's Education (Specify only highest grade co	on	16a. Deced	ent's Usual Occupa			16b. Kind of Business	s Industry
121	thin /2	Somp		ollege (1-4 or 5+)	life. DC	ind of work done a NOT use retired)	· ·		Internation Sales	onal onal
7	Hygie other	Be	17. Father's Name (First, Middle, Last)	2	ASS1S	tant Vice			Maiden Surname)	
ylan	Menta Menta arked atic ev	욘	Irving A. Tennyson	a			Les1i			
Maryland 21215-0036	s should he and 7 is m		19a. Informant's Name/Relationship (Type, Pr	1					r, City or Town, State, Z	, ,
<u>စ်</u>	f Healt item 2 other		Shirley B. Tennyson 20a. Method of Disposition			Haviland sition (Name of	1		, Maryland	
mo E	Tage nent o ant: If Iry or		1 X Burial 2 ☐ Cremation 3 ☐ Remo	oval from State cen	netery, crem	atory or other place ional Ceme	-/	Bër 16, 2009	Triangle,	, —
Baltimore,	perint. "ege! and 2 should be nied within /2 hours aner death with the Maryland Department of Health and Maryland Hogiene." Department of Health and marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses	M013	22	Name and Address	e of Eacility			vy Chase, Inc.
			23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one cau		Do not enter	r the mode of dying	g, such as cardiac	or respiratory an	rest,	Approximate
P	n sician/		Immediate Cause (Final disease or condition	Aortic Ste						Interval Between Onset and Death
E	Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):					
	±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	nce of):					
ecuted	and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):					
2 6 6 6	physician and the burial-transit	edical I	d							
os/ou	ing phy	Med	IF FEMALE:							
BOX 6	attendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnanc Live Birth 2 Fetal o Pregnant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)	У		23d. Date of de Month	elivery Day Year
the de	by the ached	hysi		Unknown	aui J	Other (specify)				
s that the	igned be det	by	Part II. Other significant conditions contributions Chronic Obstructive				en in Part I.		obacco use contribute to	
	been s	eted	onionie obblidetiv	<u>c r drinomary</u>	DISCA	.50				Probably 4 Unknown
	te has age 2 s	Completed						24a. Was autop perfo 1 \square Yes	osv prior to	utopsy findings available completion of cause of
VITAL RECORDS,	ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Pla	ice of Death (Check		2 A No 1 ⊔ Ye	s 2 No
T VIII	this co	၉	1 ☐ Yes 2 🔀 No	1 Inpatient 2 EF	R/Outpatient 8b. Time of		4 L Nursing Ho		lence 6 Other (Spec	pify)
on o	th. ; After e funer	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	28c. Injury work? M 1 🗆	at ? Yes 2 □ No	28d. Describe h	ow injury occurred	
UIVISION OT	fter des irector 1 by th	Certificate:	3 Suicide 6 Could not be	le. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (S City or Tow	Street and Number or Ru	ural Route Number,
D C	ours af		29a. Certifier 1 X Certifying Physician:		lae death o	coursed at the time	data and place on			eto d
he Hos	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Examiner: Or	n the basis of examination a ctioner: To the best of my ki	nd/or investi	gation, in my opinio	 n, death occurred at 	the time, date a	nd place, and due to the	cause(s) and manner stated.
Tot	To t		29b. Signature and title of certifier	10		29c. License			29d. Date signed (Mont	
			30. Name and address of person who comple		3a) (Tim- T	D006:	7120		November 7	, 2009
-			Matthew McAndrew, M.	D. 1355 Pic	ccard	Drive, R	ockville,	Maryla	and 20850	
	Stat Registra		31. Date filed (Month, Day, Year) NOV 1 2 2009	32. registrar's Signatur	1 de	alle				
	negistra		MIN T & 5009	Jan Jan	1					

Edward Turner State of Maryland / Department of Health and Mental Hygiene 2009 36332 1- For State Certificate of Death Reg. No Registrar Physician/ Decedent's Name (First Middle Last) 2. Date of Death Month Day November 2, 2009 Medical Examiner Edward Turner 0852 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** 215-90-9617 Country) MD 43 Months Davs Hours 03/24/1966 Director 1 XM 2 F Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 No s 23a or 28a-f shov e notified at nnce. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? South 47th. Street 637 21224 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2X No Yes White 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) . Pages I and 2 should be filed within 72 h tment of Health and Mental Hygiene. rant: If item 27 is marked other than "r or other traumatic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 Laborer Service Com 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Turner Jr. Edward Doris Cavaliery James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly 637 South 47th. Street, Baltimore, MD 21224 Turner / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/11/2009 Woodbine, MD Final Journey Crem. Donation 5 Other Specify 21 Signature of Funeral Service Lience Dorota Marshall

22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Retween Onset and /Medical Death a Methadone Intoxication and Cocaine Use Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical the attending physician and for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive cardiovascular disease Completed peen 24a. Was an 24b. Were autopsy findings available autopsy After this certificate has performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other₄ Nursing Home 5 Residence 6 Other: 1 ✓ Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification 1 Natural FOUND Pending 1 Yes 2 ✔ No Accident Nov 2, 2009 0800 hrs 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 7526 Berkshire Road, Dundalk, MD determined (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 3, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Registrar's Sign State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

1- For State Registrar		ertificate of Death	and Mental Hygi	ene Reg. No. 20	009 3633							
Physician/ 1. Decedent's Name (First Medical Examiner	st, Middle,Last) Michael Herbe	ert Vukov		Date of Death Month Day Yea Iovember 6, 2009	3. Time of Death 0640 hrs							
4a. Facility Name (if not in 105 Ferndale Av	nstitution, give street and number)	4b. City, Tow Glen Bu	, or Location of Death	4c. County								
Funeral 5. Social Security Number 214 15 010		last birthday) If Under 1			9. Birthplace (State or Foreign CountrMaryland							
Maryland A	County 10c. City	y, Town or Location Glen Burnie			10d. Inside City Limits 1 Yes 2 No							
Maryland Maryland Maryland Toe. Street and Number 105 Fernda 11. Marital Status 1 Never Married 2	ile Avenue	10f. Zip Coo	.061	10g. Citizen of Wr	•							
affer de la company de la comp	Divorced If Yes, Give Yeer	If Yes, specify Co	Hispanic Origin? (Specify ban, Mexican, Puerto Rica	an, etc.) White Varieties Specify:	- American Indian, Black, e, etc. White							
15. Decedent's Education of the than "the Medical of the Medical o		16a. Decedent's Usual Occ during most of working Arbori	life. DO NOT use retired)	Agri	cultural							
T127-039 Wental Hygiene Wental Hygiene To Cachet than a marked other than a marked other than a large of the county that a lar	Mitchell Vukov		Linda	st, Middle, Maiden Surname) Burkman								
MAC 2 D M M M M M M M M M M M M M M M M M M	v / wife	19b. Mailing Address (S 105 Fernda		Route Number, City or Town Glen Burnie,	n, State, Zip Code) Maryland 21061							
1 Burial 2 X Cre	1 Burial 2 X Cremation 3 Removal from State Removal											
I I I I I I I I I I I I I I I I I I I	to (liduage	/ 4001 Rito	hie Highway	Baltimore,	Maryland 21225							
Physician Medical raminer 23a. Part I. Enfer the diser failure. List only one Immediate Cause (Final d or condition resulting in de	isease a Hanging		ng, such as cardiac or res	piratory arrest, shock, or hea	Approximate Interval Between Onset and Death							
Sequentially list condition if any, leading to immedia	b. Due to (or as a consequence of											
if any, leading to immedia cause. Enter Underlying (Disease of injury that init events resulting in death)	lated C.	of):										
Medical I ratal	AMENDED											
23b. Was decedent pregna past 12 months?	23c. If yes, outcome of preg Live birth Pregnant at time of de	2 Fetal death	3 Ectopic pregnancy	23d. Date of o Month	delivery Day Year							
O C Signed by the defact the d D Part II. Other significant of	conditions contributing to death but not r	resulting in the underlying cause	e given in Part I.	23e. Did tobacco use contrib	oute to the cause of death? Probably 4 Unknown							
Division of Vital Records, at Director. After this certificate has been signed in by the funeral director, page 2 should be striff cation: To Be Completed To Salvand A C C C C C C C C C C C C C C C C C C				autopsy pr	/ere autopsy findings available for to completion of cause of eath? Yes 2 No							
Z5. Was case referred to n examiner? 25. Was case referred to n examiner? 1 V Yes 2 N	Hospital:	26.Pl	Other Nursing Hor	one) me 5 Residence 6	Other: Scene							
trending Physics 7 Natural 2 Accident 2 Accident 2 Accident 2 Accident 3 28a. Date of Injury Pending Investigation 28a. Date of Injury POUND: Nov 6, 2009	28b. Time of Injury 28c. I	njury at Work? 28d.	Describe how injury occurre ject hanged self									
A S S E C A Hornicide	Could not be determined 28e. Place of Injury - At h	ome, farm, street, factory, offic of residence		Location (Street and Number or Town, State) Ferndale Avenue, Glen B	r or Rural Route Number, City Burnie, MD							
29a. Certifier	(Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check											
29b. Signature and title of	e Helle		nse number	29d. Date signer November 6	d (Month, Day, Year) 5, 2009							
30. Name and address of p Carol Allan, MD	person who completed cause of death (Item Assistant Medical Examiner	,	more, MD 21201									
	4 O 0000 A A A A A A A A A A A A A A A A											

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2009 John 09 /Medical 4c. County of Death N/A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Johns Bayview Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 0 / 7 / 4 2 9. Birthplace (State or Foreign Country) MD Age (In yrs. last birthday)
67 Yrs. **Funeral** Days Hours 1**X** M 2 □ F 220-38-9908 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examination. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD N/A Baltimore Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21224 423 N. Ellwood Ave USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. African 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Self Elementary/Secondary (0-12) College (1-4or 5+) Musician 12 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname)
Lucille Brown Gregory Gough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 N. Ellwood Ave, Balt., MD 21224 Gertrude G. Walker/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 11/13/09 Hanover, MD Ardent Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hari P. Close F. Sys PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fune al Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last on cerebral Examiner as a curresquence of Hospital or Attending Physician; The law requires that the death certificate be executed ing physician and as the burial-trans Intra Crania Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an completely filled in by the funeral director, page 2. autopsy performed? res 2 No 1 □ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Registrat's Signature

09-08411 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Steven Ray Williams State of Maryland / Department of Health and Mental Hygiene 2009 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ Month Day October 30, 2009 **Medical Examiner** 0932 hrs 4a. Facility Name (if not institution, give street a 4b. City, Town, or Location of Death 4c. County of Death 605 N. East Avenue Baltimore Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex If Under 1 Year **Funeral** Age (In yrs. last birthday) Months Days Hours Min Director Country) Usual Residence of Decedent any State 10d. Inside City Limits 23a or 28a-f show notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she Director 10g. Citizen of What Country 10f. Zip Code Funeral 1. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes Yes, Give Year 2 No specify Widowed Divorce Yes 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) traumatic event, the Medical Baltimore, MD 21215-0036 17. Father Be 20b. Place of Disposition (Name of cemetery or other 3 Donation Other Specify ral Service Licensee Physician ne disease, or complications that caused the death. Do not ente Between Onset and failure. List only one cause on each line /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and transi Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Dav Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Cancer (unknown type) Completed been : 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 V No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other FR/Outnatient DOA Certification: To To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After of completely filled in by the funeral

es 2 No

Death

Year

No

Division of Vital Records, P.O. Box 68760,

1 Yes 2 No	pa				
27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe f	now injury occurred
1 V Natural 5 Pending	(Month, Day, rear)		1 Yes 2 No		
2 Accident Investigation					
3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, street, facto	ry, office building, etc.	28f. Location (S or Town, S	Street and Number or Rural Route Number, City tate)
4 Homicide determined	(Specify)			26	
29a. Certifier 1 Certifying Physician	: To the best of my knowled	ge, death occurred at ti	ne time, date and place, a	nd due to the caus	e(s) and manner as stated.
one) 2 Medical Examiner: 0	on the basis of examination a	ind/or investigation, in r	ny opinion, death occurred	at the time, date	and place, and due to the cause(s)
a	nd manner stated.				
29b. Signature and title of certifier		2	9c. License number		29d. Date signed (Month, Day, Year)
Alle Brown	(I M)		O.C.M.E.		November 12, 2009

111 Penn Street, Baltimore, MD 21201

State Registra

Medical

ORIGINAL

Melissa Brassell, MD

31. Date filed (Monti

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36336 State
Registramend #30 Per DVR G897 11/12/Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 4:50PM Wilhelm 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Egle Nursing + Rehab Social Security Number 6. Sex Lonaconing If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 M 2 KF 216-22-5802 84 Director mary land Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh **Funeral Director** MD Allegany 1 ☐ Yes 2 → No Frostburg the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Event and Injury or other traumatic event, the Medical Event in an instruction. 19706 Church Hill Road SW 21532 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No <u></u> Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) registered nurse tire company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo Roger Cadwallader Barbara Ann Garlitz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Cadwallader/brother 15317 Miners Avenue SW Frostburg, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Otner (Specify) 21. Signature of Funeral Service icensee Wade ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Mrector Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Hard disease or condition resulting in death) **Physician** CEREBROVATCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for selectneedwares of To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) the a 1 ☐ Yes 2 ☐No 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been s e 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 1 ☐ Yes 2 🗌 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the ricepture.
within 24 hours after death.
To the Funeral Director: Aft 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hickm NOVEMBER 05 2009 126907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit S. Sidhu Egle Nursing-Rehab. Center

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Lonaconing ,MD.

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND TTEM# 20a-c&22perfff, G897, T1719/09; WS

State of Maryland / Department of Health and Mental Hygiene2 0 0 9 36337 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Brenda Westbury November 2009 9:54 AM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6423 Pennsylvania Avenue #101 Forestville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Feb 1, 1963 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🂢 F South Carolina 579-90-3272 Director 46 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evandings must be notified at Director 1 ☐ Yes 2 XNo MD Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Modical Evantinat must be a 6423 Pennsylvania Avenue #101 20747 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black ò 1 ☐ Yes 2X No Specify 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 1 Í 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Westbury Sr ျ Jessie McCullough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monique Scott/daughter 1707 Benning Road NE Washington, DC 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Sther (Specify) Chambers Crematory 11-20-09 Riverdale, MD 22. Name and Address of Facili Mclaughlin Funeral Home State Anatomy Roard As Washington Reltimore, MD 2/20 King Ave. Washington 21. Signature of Forecal Service Ronald Washington, D.C. 20020 200 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) End Stage Acquired immune
Due to (or as a consequence of): **Physician** of vrs /Medical Examiner Cause (Disease or injury that initiated events in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as s been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1∐Yes 2⊿No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number line 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Type, Print) Haspital Dr. Chevely MD 20785 5th Place

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Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u>io</u>	nding tth. r; Afte e fune	tion	1 Matural 5 ☐ Pending	(Month, Day	Year)				zou. Describe fi	low injury occurred	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatus	4	the Hospi in 24 hour the Funer	edical	Check only 21 Medical Exan	niner: On the basis of o	ed.	and/or inve	estigation, in my c	me, date and place opinion, death occu	, and due to the or rred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
State 31. Date filed (Month, Day, Year) 3000 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_	To To Com	Σ	29b. Signature and title of certifier		BINH	NGUYE	N 29c. Licens	e number	2	29d. Date signed (Mon	th, Day, Year)
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Registrar NIIV 12 ZUUJ / AUGUS / 7				31. Date filed (Month, Day, Year)	32 Registrar	's Signatu	ba	New York	VI. WIT	MAM	V ZZOT	<u></u>

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 36339 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DENVER WYATT 11:10 A November 4. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 6424 Centennial Circle, Apt. A 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours Days North Carolina 223-40-4609 77 July 15, 1932 Director Usual Residence of Decedent be filed within 72 hours arreadily be filed within 72 hours arreadily be refilled at cevent, the findical Examination instituted at 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Glen Burnie Anne Arundel Director 1 Tyes 2 XINo 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 21061 USA 6424 Centennial Circle, Apt. A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 XYes 2 ☐ No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korea 1 ☐ Yes 2**X** No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Crane Operator is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Minnie Florence Osborne William H. Wyatt ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Vanleeuwen 6424 Centennial Circle, Apt. A. Glen Burnie, Maryland 21061 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran's Cemetery 11/6/09 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Signature of Funeral Service Licensee Kevin E Ecker 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** COLORECTAL CARCINOMA disease or condition resulting in death) METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sella nonegouenne offi-Examine and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No ó the 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has perform 1 ☐Yes 2 PNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P after death. Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 29a. Certifie 1 👺 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signal reand 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

N GREENEST, BALTMORE VAMC

BACTIMORE, 21201

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 36340 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day 2009 **Physician** AGNES VERONICA WARD November 8, 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Maryland Masonic Home Cockeysville 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 213-03-5102 93 Director Jan 22, 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 Anne Arundel Baltimore 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21225 201 Second Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 內 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Mother 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Miller Rose Riley ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Ward (Son) 4718 Bates Drive, Ellicott City, Md. 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 11/13/09 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Fyneral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Vascalin aunt Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trans Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as 1 IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 K No Month Day Year signed by the a d be detached for 5 ☐ Other (specify) P.0. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed рееп 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2√2 No 24a. Was an has autopsy page perform certificate 20 No the Hospital or Attending Physician: nin 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1,⊠Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29c. License number 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Wo 30. Name and address of p on who completed cause of death (Item 23a) (Type, Print) LIBERTO 3508 M). 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

36341

Baltimore, Maryland 21215-0036

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	Otate of Wil	ar yraria /	Cert	tificate of	Death	Re	g. No. 200	9 36341
Physici	an	1. Decedent's Name (First, Middle, Margaret C						2. Date of Death Month	n Day 2009	3. Time of Death
/Medio		4a. Facility Name (If not institution,				4b. City, Town, or	r Location of Death	NOVEMBE.	4c. County of De	
LAGIIIII	CI	Montgomery Gen	-	al		01ne	y		Montgon	
Funeral Director		577-54-6727	5. Sex 7. Ago 1 □ M 2 🖾 F	e (In yrs. last b	yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, September	Year) (irthplace (State or Foreign Country) hington, D.C
f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	merv	10c. City, To	wn or Loca	ation Wheat	on			10d. Inside City Limits 1 ☐ Yes 2X No
or 28a-	Directo	10e. Street and Number	<u>-</u>			10f. Zip Code		10	og. Citizen of What C	ountry?
23a c	ralD	3919 Ilford R	oad			2090			United St	ates
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show any Injury or other traumatic event, it a Marical Examination in the Indifficulty or other traumatic event, it a Marical Examination in the Indifficulty one.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			as Decedent of H Yes, specity Cuba □Yes 2【本No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
ne. Nedical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			Sa. Decede (Give k life. De	ent's Usual Occup ind of work done on ONOT use retired	oation during most of work d)	sing	16b. Kind of Busines	s/Industry
dygier ther that nt, tr		10 17. Father's Name (First, Middle, La	9ef)	j	Home	maker	18. Mother's Nam	e (First Middle N	Own Home	
ental ked ol	To Be	Luther C. B						nerine E.		
alth and M 27 Is mar r traumat	-	19a. Informant's Name/Relationshi			_				City or Town, State	
ent of Heanut: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			of Dispositery, cremit	ition (Name of atory or other place Ym, Inc.	Novem	ober 12	Bethesda,	Maryland
Departm Importa any Inju		21. Signature of Funeral Service Li	eensee7 (7	 D1498	Ro Ro	Name and Addre CKVIIIe, CKVIIIe,	ss of Facility Rob Inc. 300 Maryland	Pert A. F West Mo	Cumphrey Fontgomery	uneral Home/ Avenue
nysician Medical		23a. Part 1. Enter the disease, or c shock, or hi art failure. List o Immediate Cause (Final disease or condition resulting in death)	a	pli	o not ente	r the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence	las	e tol	etion ral de	lease		
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. if yes, outcome 1 Live birth 4 Pregnant at	2 Fetal dea		Ectopic pregnanc Other (specify)	у	5	23d. Date of d Month	lelivery Day Year
d be deta	by	Part II. Other significant condition	es contributing to death but $P = Q + Q + Q$	ut not resulting	in the und	derlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
ate has bee	Completed			Pu	lmo	nary	dien.	24a. Was ar autops perform 1 □ Yes 2	y prior to	
ertifica ctor, p	Be C	25. Was case referred to medical examiner?						th (Check only one		
this c al dire	္	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 🛕 Inpatie	ent 2 ER/C	Outpatient		4 Li Nursing H		ence 6 Other (Sp	necify)
death. ctor: After y the funer	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion (Month, Day	y, Year)	Injury		yat k? Yes 2 □ No		w injury occurred	Rural Route Number,
ours after leral Dire filled in b		4 ☐ Homicide determin	building, etc Physician: To the best	; (Specify)			me. date and place	City or Town	, State)	
n 24 h	edical		xaminer: On the basis of and manner sta	examination						
withi To th	ž	29b. Signature and title of certifier	ua h	10.		29c. Licens	e number 9 9 9	29	9d. Date signed (Mo	nth, Day, Year)
		30. Name and address of person w					0.1	M 1	-1 20022	
Cha	10	Aruna Paspula 31. Date filed (Month, Day, Year)	T				ce, Oiney	, riaryla	11IG 20832	
Sta Registr		10119	32. Jegistra 2009	~ A.	40	de				
47 D 4/0/	201	MATE	- Jan-		7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36342 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** W: OLAM 11 Rebecca Ann Watson /Medical give street and number) 4c. County of Death Facility Name (If not institution, 4b. City. Town, or Location of Death Examiner IMOVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 220-36-1494 **Director** 68 May 5. 1941 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ? Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modical Experimental by matthed at MD Catonsville 1 ☐Yes 2 TNNo Director Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 21228 USA 407 Waveland Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 A Married 2 No White 1 ☐ Yes 2 🛣 No Specify Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Secretary Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Friski Mary Ann Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Forrest Daughter 407 Waveland Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 11/11/2009 Elkridge, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Li 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 105 C disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) the detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s W. 06 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 00 2 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☐ER/Outpatient 3☐DOA 1 Yes 2 No 1 Inpatient Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760, o. ۵. Records, Vital Division of

72 hours after death

Maryland 21215-0036

altimore,

Physician: Hospital or Attending 24 hours a

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

within 2.

			1 - State of Maryland / Departn State of Maryland / Departn Certific	nent of Health and I cate of Death	Mental Hygie Reg.	ne 2009	36343
	Physicia		1. Decedent's Name (First, Middle, Last) Leonore Smart Wetherill		2. Date of Death Month	Day 4 Year	3. Time of Death
	Medic Examin			City, Town, or Location of Death		4c. County of Deat	
	Funeral Director			Under 1 Year If Under 24 Hrs. hths Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan. 13,	9. Bird	hplace (State or Foreign untry) New York
		'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1	Dune 10;	1525	10d. Inside City Limits
	Maryla 28a-f s otified	irecto	MD Baltimore Lutherville				1 🗆 Yes 2 🔽 No
	vith the 23a or st be n	Funeral Director		of, Zip Code 1093	US	. Citizen of What Co	untry?
0030	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto		14. Race - Ame Black, White	
7-61212	within 72 hou jiene. er than "natu the Medical	Completed	(Specify only highest grade completed) (Give kind of	Usual Occupation of work done during most of work Tuse retired)	king	o. Kind of Business	Industry
and	be filed tental Hyg rked other ic event,	To Be	17. Father's Name (First, Middle, Last) S. Bruce Smart		ne (First, Middle, Maid		
, Mary	d 2 should alth and M 1 27 is mai er traumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	dress (Street and Number or Rui herspoon Road;	ral Route Number, Cit		
more,	Page 1 an nent of He ant: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Peremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cemetery, crematory Hilltop Ser	(Name of y or other place) vice Corp. 11/	I .	wson, MD	Town, State
Baitimor	permit. Departn Imports any inju			me and Address of Facility Towson Funera	l Home, In		York Road on, MD 21204
	Tiysician/	21	23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition ANGINA	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of): GIANT CELL ARTEF	RITIS			2 YEARS
	ited d ansit	amine	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury				
9	s be exect /sician an e burial-tra	edical Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):				
. Box ba/bu	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. Within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ect 4 ☐ Pregnant at time of death 5 ☐ Oth	opic pregnancy ner (specify)		23d. Date of de Month	livery Day Year
S, P.O.	uires that the signed by all the deta	술	Part II. Other significant conditions contributing to death but not resulting in the underl	lying cause given in Part I.			the cause of death?
Records,	The law requate has bee page 2 shou	Completed			24a. Was an autopsy performed 1 🔲 Yes 2 🌡	prior to	topsy findings available completion of cause of
VItal	siclan: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 FR/Outpatient 3	26. Place of Death (Chec	ck only one)		
on or v	nding Phy ath. : After this e funeral d	icate: To	1	28c. Injury at work?	ome 5 Residence 28d. Describe how i		ify)
UIVISION	al or Atters s after des il Director	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S		ral Route Number,
-	ne Hospit n 24 hour e Funera	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur of the basis of examination and/or investigation only one) 2 Certifying Nurse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred	at the time, date and p	lace, and due to the	cause(s) and manner stated.
	To the within to the comp		29b. Signature and title of contifier	29c. License number D34193		Date signed (Monte	
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		/	/	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	DRIVE TOWSON	MARYL	and 2120	14

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 36344 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** [□]gy, 20ď9 11:28 P M November Margaret T. Watson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Harford 300 West Ring Factory Road If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Months 6/18/1918 1 □ M 2 🙀 F 91 225-18-3299 Director Virginia Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedfied Examine must be motified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No Director MD Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 300 West Ring Factory Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2☐No þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Parks James Turlington, Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward Watson / Son 1803 Falstaff Court Bel Air, Maryland 21015 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p ν Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Lawn Cem. 11/14/2009 Onancock, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Europeal Service Licensee INW Ruck Towson Funeral Home, Inc. 1050 York Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or s a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause to be according that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physlcian: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an has perform 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 200) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Relow in LISWIND-Phan 5 ar sall 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36345 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ NOVEMBER 200[°]9 ARNOLD WILDER 6:27 A M STEWART Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthplace Country) **Funeral** Months Days Hours Min. 10-20-1955 213-48-0218 Director 54 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director N/A 1 K Yes 2 □ No ALEXANDRIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6439 RICHMOND HIGHWAY, #102 22306 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: Completed 3 Divorced 4 Divorced WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ACTUARY INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILDER **ERVIN** NATALIE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN WILDER/BROTHER f Health item 27 3511 GARDEN VIEW ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 11-09-2009 BALTIMORE. SOL LEVINSON & BROTHERS Signature of Funeral Service bicer 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complication of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Stoke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner woring arre Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or iinjury repair an gothe anewsism that initiated events resulting in death) Last signed by the attending physician Completed by Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death 1 Yes 2 9 Unknown 9 | Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 25. Was case referred to medical examiner? Vital æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident injury 5 Pending ivision within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Man R149194 November 9, 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tousun Grut 21204

Registrar

State

31. Date filed (Month, Day, Year) 1 2 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 36346 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4:43 PM M Quan Y. Xu October 31, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 ☐ M 2 💢 F Months Days Hours unk 220-45-5870 63 Oct 10, 1946 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examine must be notified at 10a. State 10b. County 1 ☐ Yes 21 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 USA 2201 Shorefield Road #921 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify: asian Ď 3 ☐ Widowed 4 ☐ Divorced Completed unk unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 70 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18101 Prince Philip Drive Onley, MD 20832 Montgomery General Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other (Specify) in state 21. Signatur of Funeral Society icenses and an artist Society of Funeral Society icenses and artists of the society of the soc State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or andition resulting in the holes **Physician** - 21 dies /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to as a consequence of requires that the death certificate be executed Khabdomye Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the o 9 Dunknown 9 Unknown σ. signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nes 2 No declined 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After t 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier Med Direct 29c. License number 1050410 Dont Ears dren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Dr. Olney MD 18101 16hac Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10,2009 November 2:00A /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 3502 Northwind Road Parkville Balto. 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours December 2,1935 219-38-0322 73 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner must be notified at once. Md. Balto. Parkville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3502 Northwind Road 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William J. Cordle Anne M. Cremen ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Northwind Road Parkville, Md. 21234 Edward Zang, Jr. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Highview Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-14-2009 Fallston, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. 21236 Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OBSTR MRONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2XN0 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) ERKRO KNOW LOND 21083 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland		rtment of H tificate of L		vientai Hyg	giene Reg. N	2009	363	48
	Physicia	an	1. Decedent's Name (First, Middle						2. Date of Dea Month	ath Day	Year	3. Time of	
	/Medic	al	Herman Ziffer 4a. Facility Name (If not institution				4b. City, Town, or	Location of Death	11/6/		County of Deatl	9:35	A ^M
	Examin	er	10503 Drumm Ave				Kensingt				ntgomer		
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da			hplace (State ountry)	or Foreign
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	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside C	ity Limits
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	or 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	untry?	
	th wit	Funeral Director	10503 Drumm Ave	2.			20895			Unit	ed Stat	es	
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	. 1	 Race - Ame Black, White 		
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yland	d be f ental I ced ol	o Be	Israel Ziffer	Lasty				Beatrice			oarrarro)		
3	should and Mark mark	ဂ	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailin	g Address (Street a				Town, State, Z	Zip Code)	
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ore	les 1 a	1 3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Placen	ce of Dispos netery, crem	sition (Name of natory or other place	e)	Date	20c. Loc	cation - City or	Town, State	
	t. Pag tment tant;	1 8	4 ☐ Donation 5 ☐ Other (S	pecify)	Ches		e Cremato		/2009		tsville		00010
Baltimor	permit. Pages 1 and Department of Heal Important; If Item 2 any Injury or other Once.		21. Signature of Funeral Bervice	Licensee	gpaner		Name and Addres	•	nation S		933 Gis Silver		100
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximation	tween
	Physician		Immediate Cause (Final disease or condition	a_Failure	To Th	ırive						Onset and	Death
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5	Physician: The law rithis certificate has b ral director, page 2 sh	o Be	examiner? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	Hospital: 1 Inpati	ent 2□El	B/Outpatien	t 3 DOA Othe	26. Place of Deat	ome 5. XResio		i ∏Other (Soe	cify)	
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1			30. Name and address of person Robert H. Gerard	·			•	r Spring	MD 2001	0			
1	Sta	te	31. Date filed (Month, Day, Year)	1 0 2000 PG	rar's Signatu	re /	Land Dire	- philip					
	Registr	ar	NUV	T.S. COO3	Part of the same of	19:17	4						

State of Maryland / Department of Health and Mental Hygiene 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTO BEE **Physician** 2009 1:00 AM Alexander Beatrice Bertha /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Lanham Doctor's Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2X F Months 90 231-26-9177 June 9, 1919 Director Virginia Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'ra Medical Examinar must be notified at 1**∑**Yes 2 □ No Director Washington D.C. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Street and Number N.W. 1050 New Jersey Ave., Apt.#316 20001 U.S. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important; If item 27 is marked other than "natural", any Injury or other traumatic event, Ital Medical Exagone. 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Communications Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Ford Rainey Wells ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 9545 Noble Dr., Upper Marlboro, MD 20772 Redell Duke-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-30-09 Washington, D.C. Mt. Olivet Cemetery 21. Signature Funeral Service Licensee 22. Name and Address of Facility Bonnette & Assoc. Funeral Home Inc. N.E. WDC 20018 ann 23a. Part 1. Inter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner typernatremia Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a on equence of) Examine requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 ☑No P.0. 9 Unknown 9 🗆 Unknown signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed certificate 1 □Yes 2 🖺 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ▼Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifie completely (Cheq one and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 NYAMI 30. Name an Address of person who completed cause of death (Item 23a) (Type, Print) 101A GREENBEIT MD 20770 7500 Hanover PWKY 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmended#23perCRNP FCHD 10/27 Pertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER Day **Physician** 930 2009 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Nursina ockville Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛱 F 99 279-05-1018 Director March 10, 1910 Ohio Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho ty⊡Yes 2 □ No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 1235 Potomac Valley Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Wedgal Experiment Black White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. 2 Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Warren Oscar Braucher Lottie May Breckenridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita A. Murphy - Daughter 8413 Dasher Court, Gaithersburg, Maryland 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 10/29/09 Columbia, Maryland 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Sign sture of Funeral Service License hereit 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ta month /Medical Due to (or as a consequence of): Examiner End Stage Dementia Sequentially list conditions, if any, reading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner but to (or se a consequence of) Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 🖬 No ed by the detached f 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown icate has been si , page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 □ Yes 2 ₽No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, Attending Physician:

certificate be executed

P.O. Box 68760,

burial-tran and

director,

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

show

death v

3altimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

no ano

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and manner stated.

ROBERD

31. Date filed (Montl 32. Registrar's Signature 10110 Molecular Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death October 24, 2009 Physician Elaine Sheehy 5:00 Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 586 Cynwood Drive Easton Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 577-46-0225 1 □ M 2 T F 75 **Director** 01/08/1934 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at 1 ☐ Yes 2 No Director Maryland Talbot. Trappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21673 3831 Harrison Circle USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2**X**]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ Specify: white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 administrative assistant federal government Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Pages 1 and 2 should be 1 nent of Health and Mental Edward Sheehy Helen Lynch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a,
Important: If Item 27 Is
any Injury or other trau 904 S. Washington St., Easton, MD 21601 Timothy Brown/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, MD Anatomy Gifts Registry 10/26/09 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Holloway Tufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ENo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Talbot Hospice examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) House Medical Certification: To 1 ☐ Yes 2.2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this. After th funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural n 24 hours after death.

In Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar Commerce DR

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

32. Registrar's Signature

do.

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2009For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** OCTOBER 2009 4:25 PM 25 REBECCA BARNETT L. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WORCESTER OCEAN PINES CATERED LIVING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2 🕅 F MARCH 14, 1927 WASHINGTON, DC 82 Director 579-36-7791 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Wealcal Examiner must be notified at 1X Yes 2 □ No Director OCEAN CITY MARYLAND WORCESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with USA 21842 503 HARBOUR DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: WHITE If Yes, Give X Specify þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER permit. Pages 1 and 2 should be file. Department of Health and Mental Hive Important: If then 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCIS DERMER ISABELLA ဥ BAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 503 HARBOUR DR, OCEAN CITY, MARYLAND 21842 PATRICIA ILCZUK-LAVANCEAU/FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 10/26/09 CREMATORY OF DELMARVA DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature f Funeral Service Licensee How HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Constite **Physician** disease or condition resulting in death) /Medical Due to (des a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a conse uence of Examiner the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician P.O. Box 68760, The law requires that the death certificate be Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon 1 Yes 2 No 9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the a detached 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2No 24a Was an certificate has autopsy performed? Yes 2 page 2 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check onl one) Be examiner? ASSISTED Other: 4 Nursing Home 5 Residence 6 Nother (Specify) LIVING 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and marine as season.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Berlin, NO 21811 U

State

Registrar

. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:50 P M MARNA EILEEN DUQUETTE BENJAMIN 10/31/2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DORCHESTER DORCHESTER GENERAL HOSPITAL CAMBRIDGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕅 F 90 9/21/1919 ILLINOIS Director 148-07-1729 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show 27 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Exeminar must be notified at 1 ☐Yes 2XINo Director **CAMBRIDGE** MD DORCHESTER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 779 COOKS POINT RD. 21613 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: 9 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LICENSED PRACTICAL NURSE HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE DUOUETTE MARGARET EILEEN SHEEHAN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. DAVID DUQUETTE BENJAMIN / SON 779 COOKS POINT RD., CAMBRIDGE, MD 21613 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State DORCHESTER MEMORIAL PARK 11/6/2009 CAMBRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MEATS 0104917 Medical Due to (or as a consequence of) Examiner CARS DECTEMSION Sequentially list conditions, if any, leading to immediate cause. Enter Unverlying Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Lect 10 2 200 1 ☐ Yes 2 ☐ YN Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Do Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 ☐ Yes 2 🗌 No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Los

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

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32. Registrar Signature

Physician
/Medical
Examiner

Fune Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Evander Lust be notified at

Baltimore, Maryland 21215-0036

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

siçi	an	1. Decedent's Name (First	t, Middle, Lasi	")							Date of I Month		ay	Year	3. Time of	Death
dic		BOI	BBY R	. CRUM							OCT.		2009		3:15	A M
nin	er	4a. Facility Name (If not in	stitution, give	street and number	r)		4b. City, 7	Fown, or	Location of	of Death		4	c. County o	f Death		
		Shady Gro	ve Adve	entist Ho	spital	.	R	ockv	<i>r</i> ille				MONT	GOME	RY	
ral		5. Social Security Number	_		ge (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of I	Birth Day Yea	r)	9. Birthp	place (State o	r Foreign
or		218-56-62	52	M 2□F	67	Yrs.	WIOTITIS	Days	1 louis	Will I.	Mar.	9, 1	942	Ma	ryland	1
		Usual Residence of Deced														
	_		County		10c. City,	Town or Loc								1	0d. Inside Ci	
	cto	MD I	Montgar	nery		Roc	kvill	.e							1X Yes	2 □ No
	jre	10e. Street and Number					10f. Zip	Code				10g. C	citizen of W	hat Coun	itry?	
	a	509 Bickfo	ord Lai	ne		20850							U.S.A	•		
	nei	11. Marital Status		12. Was Decedent	t Ever in U.S.	13. V	Vas Decede	ent of Hi	spanic Ori	gin? (Spec	cify Yes or I	No-			an Indian,	
	ī	1 Never Married 2	Married	1 ☐ Yes 2 ☐	No						iicari, etc.)			, White, e	ack	
	db	3 ☐ Widowed 4 ☐ Di	ivorced	Year or Dates:		1 ☐ Yes 2 🔀 No Specify: Specif							Specify:	DI	ack	
	Be Completed by Funeral Director	15. Do	ecedent's Edu highest grad	cation le completed)		16a. Deced	ent's Usual	Occupa	ition	t of working	a	16b.	Kind of Bus	iness/fnc	dustry	
	du	Elementary/Secondary (College (1-4or	5+)		kind of work OO NOT use			i or working	9					
	Ö	llth				A	uto D	etai	.ler			I A	uto S	hop		
	Be	17. Father's Name (First, I							18. Mothe	r's Name	(First, Midd	lle, Maide	n Surname)		
	ည	Arthur C	rum]	Pearl	. Craw	ford				
		19a. Informant's Name/Re				19b. Mailin	g Address	(Street a	nd Numbe	er or Rural	Route Nun	nber, City	or Town, S	tate, Zip	Code)	
		Carolyn C	rum (Wi	ife)		509 B	ickfo	rd I	ane,	Rock	ville	, MD	2085	0		
		20a. Method of Disposition			20b. Plac	ce of Dispos netery, crem	sition (Name	e of	,	Da	ite	20c.	Location - C	ity or To	wn, State	
		1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O				eck M			1	11/7	/09		lney,	MD		
9		21. Signature of Funeral S				22	Name and	Addres	s of Facilit	•	•		RAL H		P.A.	
ouce		(store	a R.	A	0.					-			le, M	-		
		23a. Part 1. Enter the di	ase, or comp	carrins that cause	ed the death.	Do not ente	er the mode	of dvino	a, such as	cardiac or	respiratory	arrest			Approximate	
۱		shock, or heart failui Immediate Cause (Final	List only of	ne cause on each I	line.				,,		roop natory	arroot,			Interval Bet Onset and [ween
ın al		disease or condition resulting in death)	Vasc	cular	Acci	dent										
er					s a consequer	enal Failure										
۰	-	Sequentially list conditions	,													
	in	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	* <	Due to (or as	s a consequer	ice or):										
	xan	that initiated events resulting in death) Last		Due to /or or	a consequer											
	쁘			Due to (or as	s a consequer	ice oi):										
	g			j												
	cian/Medical Examiner	IF FEMALE:			-570											
-	an	23b. Was decedent pregna in the past 12 months	anı	3c. If yes, outcome 1 ☐ Live birth	2 Fetal de	eath 3 🗆	Ectopic pre	egnancy				- 4	23d. Date		,	
		1 ☐ Yes 2 No	·	4 ☐ Pregnant a 9 ☐ Unknown	at time of dea	th 5□	Other (spe	cify)					Mont	ın	Day Y	ear/
	Completed by Phys	9 Unknown					-									
	2	Part II. Other significant c	onditions cor	ntributing to death t	but not resultir	ng in the un	derlying ca	use give	n in Part I.		23e. Dio	tobacco	use contrib	oute to th	e cause of d	eath?
	P G			· · · · · · · · · · · · · · · · · · ·							1 🗆	Yes 2	2 ☐ No 3	Prob	ably 4 🔼 L	Jnknown
-1	be										24a. Wa		24b. W	ere autop	osy findings a	available
	E										per	opsy formed?	de	ath?	npletion of ca	luse of
	ပ္	25. Was case referred to m	nedical						26 Blace	of Dooth	1 □Yes Check only		0 11	Yes	2 LJNo	
	Be	examiner? 1 ☐ Yes 2 🔀 No	<u> </u>	lospital:	iont 2 🗆 E	R/Outpatient	2 C DO	Tour.		,						
	٦	27. Manner of Death		28a. Date of Inju	ury 28	Bb. Time of		c. Injury	4 LI INU				6 Other		<u>()</u>	
	<u> </u>		Pending investigation	(Month, Da	ay, Year)	Injury	м	Work?	o es 2∐1		G. 20001181	o 11011 111gi	ary occurred	•		
	<u> </u>	3 ☐ Suicide 6 ☐ 6	Could not be	28e. Place of Inj	iury - At home	a farm stro			C3 L		tf Location	(Street o	nd Alumba	or Pum	l Route Num	t a s
	声	4 ☐ Homicide	determined	building, et	tc. (Specify)	, iaiii, 0.10	ot, lautory,	omoo		20	City or To	own, Sta	le)	or nurar	noute Num	Jer,
į.	<u> </u>	29a. Certifier 1 ☑ Ce	ertifylna Phys	sician: To the best	of my knowle	dre death	occurred a	t the tim	o data an	d place or	ad due to th	0.0011001	a) and man		totod	
	Medical Certification: To	(Check only 2 Me	estigation, i	in my op	inion, dea	th occurred	at the time	e, date ai	nd place, ar	id due to	the cause(s)	,				
	ğ Z	29b. Signature and title of o		29c	License	number			29d. D	ate signed	Month F	Dav. Year)				
	Orifugaly m.D.									505						. 0
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							D0065505 October 25, 200				7				
		30. Name and address of p	erson who co						A		A =		6			
		31. Date filed (Month, Day,		32 Dociety	nar's Signatur	701	MZDIC	CAL	C E1	VTOR	DR	. /	COCKI	177	E M.	0
stat stra	_		^{7 ear)} 200	Q /	a Signatur	hor	Red									
- 11 () -		001 /	0 0 ZUU	J Cerus	- p.	1900										

Registrar

Amend Item 23aPt11 per me, g897, 11/30/09dnb. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - Famend Item 25 per me, g897, 11/24/09dnb, 23aPt11
Registrar AMFND#23a-1+2perMD, 11/4/09, FMW, MOD

1. Decedent's Name (First, Middle, Last)

2. Date of Death

2. Date of Death 3. Time of Death oct. 25, 2009 Physician Narcisa Chavez 9:13ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville 11438 Schuylkill Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 0 / 29 / 1 9 4 0 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 □ M 2 🛛 F Nicaragua 579-62-1958 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modest Exercites rises to notified at 1X Yes 2 □ No Rockville Montgomery Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 USA 11438 Schuylkill Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1XIYes 2□No Specify:Nicaraguan White Specify: þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cosmotology Beautician 18. Mother's Name (First, Middle, Maiden Surname)
Maria Irene Gutierrez 17. Father's Name (First, Middle, Last) Be Jose Maria Zepeda ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) German Chavez/Husband 11438 Schuylkill Road Rockville, Md. 20852 Department of Healt Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 Removal from State Parklawn Mem.Park 10/28/2009 Rockville,Md. 4 ☐ Donation 5 ☐ Other (Specify) P計型型Pd Appres RTT PALDI FUNERAL SERVICE, P.A uneral Service Lice 9241 Columbia Blvd.Silver Spring,Md20910 23a, Part1. Emir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final pulmonary -7 minutes **Physician** (ardio disease or condition resulting in death) /Medical Due to (or as a consequence of): Aspiration Pneumonia **Examiner** Se uential, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Sphag 19 or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical CERTIFI IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Brain 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Persistent Vegetative State has autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1K Yes 2⊞No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D0032654 Oct.27,2009 MD 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) John Serlemitsos M.D. 2033 Penderbrooke Dr. Crownsville, Md 21032 31. Date filed (Month, Day, ¥ear) 2. Registrar's Signature State 29 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2345 October 25 2009 Jesus Armando Centeno /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/26/1939 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☑ M 2 ☐ F Venezuela 583-01-3479 69 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show event, the Medical Examiner rust be notified at 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomeru 1 and 2 should be filed within 72 hours after death with the I Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Venezuela 14610 Tunewick Terrace 20906 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: Venezuelan 1 X Yes 2 No Specify: ò White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Courier Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Lesmes Ortiz Manuel Joaquin Centeno ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health au Important: If item 27 Is any injury or other trau once. John J. Centeno - Son 1208 West Newport Avenue, Chicago, Illinois 60657 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lincoln Crematory 11/03/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failed. List only one cause on each line. Immediate use (Final disease or condition resulting in death) **Physician** -nd Stage V /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence of) Examine law requires that the death certificate be executed and -tran Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the the the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician; The certificate 2 No 1 ☐Yes 2 🔀No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2□No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 1 Certification: 1 Natural 2 ☐ Accident 5 Pending investigation in 24 hours after the Funeral Director: After Funeral Director: After Funeral Director: After Funeral 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9inh M 2009 Bichhuom BICHMUNG MINH DINK M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip , MD 20832 18101 Vive 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 29 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene, 36357 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Antoinette Lucia Cockshott 8:30 РΜ October 23, 2009 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 194-30-9141 70 December 13,1938 Lehigh, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits if than "natural", or items 23a or 28a-f sho Directo 1 XYes 2 No Maryland | Montgomery Silver Spring the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11411 Columbia Pike, #B-3 20904 by Funeral USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Credit Department Supervisor and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fir f Health and Mental F tem 27 is marked off Be Lewis Stampone ပ Ruth Willowby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin H. Cockshott / Husband 11411 Columbia Pike, #B-3, Silver Spring, MD 20904 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metropolitan Crematory 11/2/2009 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 6 Ay (logers Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner Metastatic Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of): sician and burial-tran COPD Exacerbation Due to (or as a consequence of) O. Box 68760. the attending physician hed for use as the buria death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe 1 □Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) this c Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral ! filled 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title or certifler 29c. License number 29d. Date signed (Month, Day, Year) D68686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick D. Min, 2101 Medical Park Drive, Suite 200, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 9 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:33 PM DOROTHY PAULA CLOYD OCT 27 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BETHESDA MONTGOMERY NATIONAL NAVAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days Hours 1 □ M 2 □ F 461-30-0815 85 JUNE 8, 1924 TEXAS **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be ruffled at 1 ☐ Yes 2 ☐ No Director VIRGINIA FAIRFAX MCLEAN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6251 OLD DOMINION BLVD # 348 22101 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER 12 5+ OWN HOME Pages 1 and 2 should be filed vent of Health and Mental Hygient: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN FRAZIER un-avail. ပ္ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES DANIEL CLOYD - SON 540 SECOND ST. #103 ALEXANDRIA, VA 22314 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury EDITH FORD MEMORIAL NOV. 14, 2009 CANADIAN, TX 4 Donation 5 Dother (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON ST. ALEXANDRIA, VA 22314 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HODGKIN'S LYMPHOMA disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical as IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 ☐ Yes 2 ➡ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 Npatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director; 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the complete in the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the c 29a. Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Date signed (Month, Day, Year) 29b. Signature and title of coctifier 0101242259 (VA) NATIONAL NAVAL MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 BETHESDA MD 20889-5600 JAMES E. STANTON LT MC USN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State back Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36359 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24, 2009 October 1933 M George Robert Corbin 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3503 Randall Road Suitland Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Voor) Days 1 ☐ M 2 ☐ F 579 54 5807 63 Aug 8, 1946 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2□No XX St. Marys Hollywood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 42485 Helen Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ★YYes 2 □ No 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married Typy Yes 2 □ No
Types, Give
Year or Dates: Vietnam 1 ☐ Yes P No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Raymond Corbin, Sr. Dorothy Louise Haggenmaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42485 Helen Court, Hollywood, MD 20636 Ronnie E. Corbin (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ X Yial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 10/28/2009 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral home, Inc 6633~01d21, Signature of Funeral Service Licensee Moor 5 Malexanria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final GASTROINTESTINA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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MD

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the World Examination must be notified at

Je filed wis. ۱۱ Hygiene. ۱۳ **than** ۳۳

12 should be filed wi h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once.

3altimore, Maryland 21215-0036

Examine burial-transi attending physician for use as the burial Physician/Medical signed by the a d be detached f Completed by his certificate h I director, page spital or Attending Physician: Ti hours after death. uneral Director: After this certificate ly filled in by the funeral director, pa Be Certification: To

law requires that the death certificate be executed

Box 68760,

P.O.

of Vital Records,

Division

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> 24a. Was an autopsy performed 1 □Yes 2 2No 26. Place of Death (Check only one)

Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

25. Was case referred to medical examiner 1 ☐ Yes 2 ☐ No 27 Manner of Death 1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

5 Pending investigation

determined

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b Time of

Other: 4 Nursing Home 5 Residence 6 other (Specify) thers Home 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHUADON 300/ HOS

31. Date filed (Month, Day, Year)

32. Régistrar's Signature

To the Hospital within 24 hours a To the Funeral I

Medical

State Registrar 09-08477 James Calvert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 36360

		1- For State Certificate of Death	Re	eg. No.		
Physici dical Exami		1. Decedent's Name (First, Middle,Last)	Date of Deat Month November	h Day Year	3. Time of Death 1700 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	ath	
=6 		46860 Hilton Drive Apt. 2511 Lexington Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	To Date of Bird	St. Mary's	Distribution (Otata	
Funeral Director		120-58-5812 1X M 2 F 40 Yrs. Months Days Hours Min.	→	h(MM/DD/YYYY) 9. , 1969	eign Country) VA	
any	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show. ent, the Medical Examiner must be notified at once.		MD St. Mary's Lexington Park			1 Yes 2 X No	
		10e. Street and Number 46860 Hilton Drive, Apt. 2511 10f. Zip Code 20653		og. Citizen of What C	ountry?	
		11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No		14. Race - Am White, etc	erican Indian, Black,	
s after iral", o	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specifiy: 1 Yes 2 X No specifiy:		оросиу.	hite	
'2 hour "natu	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retirementary (0-12)	red) .	16b. Kind of Busines	,	
036 vithin and ene.	Completed	12 4 Software Engineer - La Syst	inding tems	US Gover	nment	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours nt of Health and Mental Hygiene. It: If item 27 is marked other than "natur other traumatic event, the Medical Exami	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name Jerome Robert Calvert Virgin		Maiden Surname) oell Liebl	ich	
D 212 should be and Menta 7 is mark natic even	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R				
and 2 sho lealth and tem 27 is traumati	·	Jerome R. Calvert - Father 320 Pine Forest Drive	Ext., (Greenville	, SC 29601	
ore, es l an of Heal If iten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	·	
		4 Donation 5 Other Specify: Metropolitan Crematory 11	/03/2009	Alexandr	ia, VA	
Baltin permit. P Departme Importar injury or		21. Signature of Funeral Service Licensee Kenneth Phifer per DVR 22. Name and Address of Facility Mattingley-Gardine P.O. Box 270, Leon	r Funer ardtown	al Home, 1 , MD 20650	P.A.	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and				
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, b.				
Box 68760, cleath certificate be executed the attending physician and of for use as the burial - transit	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	Examiner	events resulting in death) Last Due to (or as a consequence of):				
		UNPENDED X AMENDED #21 per dh,g897,11/12/09dhb				
		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	ery	
	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ncy	Month	Day Year	
Box 687 he death certific the attending p	Physicial	1 Yes 2 No 9 Unknown 9 Unknown			i	
ds, P.O. equires that the een signed by a util be detached.	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?	
	ted		24a. Was a		autopsy findings available	
COr e law re e has be	Completed		autops	sy prior t med? death	o completion of cause of	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as		25. Was case referred to medical 26.Place of Death (Check only one)				
	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; A Nursing Home 5 Residence 6 ✓ Other: Scene				
	Ë	(Month, Day, Year)	28d. Describe h	ow injury occurred		
ivisior or Attend after death Director:	ertification:	2 Accident Investigation 28e Place of Injury. At home farm street feeton office building etc.	206 Landing (C	troot and Number or	Dural Bouta Number City	
Divi	ertifi	Suicide 6 Could not be determined (Specify)	or Town, St		Rural Route Number, City	
To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)				
To vit	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)	
		Whe Sanel wid O.C.M.E.		November 2, 2	009	
		30. Name and address of person who complèted cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
St	ate	31. Date filed (Month, Day, Year) 82. Registrar's Signature	21201			
Regist		110 110 110 110 11 11 11 11 11 11 11 11				

State of Maryland / Department of Health and Mental Hygiene 36361 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month OCTOBER CHRISTINE LUND DYKER 2009 7:30 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗹 F Months Days Hours 83 Director 579-30-3887 DEC 24 1925 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Evanisher mast be notified at Director 1 ☐ Yes 2 No FREDERICK DICKERSON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? s 1 and 2 should be filed within 72 hours after death v if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23s by Funeral 20842 USA 9009 SLATE QUARRY ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ₩idowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DALMATIAN BREEDER DOG BREEDING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ADA OLIVER JOHN LUND Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 90265 BARBARA DIJKER / DAUGHTER 30765 PACIFIC COAST HWY.#160, MALIBU, CA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State STAUFFER CREMATORY 10/27/09 4 ☐ Donation 5 ☐ Other (Specify) FREDERICK, MD Se Licensee 22. Name and Address of Facility
HILTON FUNERAL HOME 21. Signature of June P.O. BOX 86, BARNESVILLE, 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD **Physician** disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) certificate be executed Causs (Disease or inju-that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760, physiciar Physician/Medical as the IF FEMALE for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) the a ☐Yes 2 No 9 Unknown 9 I I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No After this certificate 2 No 1 ☐ Yes 1∐Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2\ No P 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? To the Hospin...
within 24 hours after deam.
To the Funeral Director: After remainered in by the fur 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Fauzi Rizvi, MD October 26,2009 MDD62180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th Street Frederick, MD 21701 MD KIZU! 31. Date filed (Month, Day, Year) 32. Registra s Signature State 2009 ▶ OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36362 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Charles Danford Huey 10 11:00 /Medical 4a. Facility Name (If not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death Hospice at the alisbun NICOTNICO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. 09/28/1936 416-54-0380 73 Director Alabama Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show 10d. Inside City Limits Maryland Worcester Berlin Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 79 Club House Drive 21811 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dept. of U.S. Army Elementary/Secondary (0-12) College (1-4or 5+) p rmit. Pages 1 and 2 should be filed wit D partment of Health and Mental Hygien In portant: If Item 27 is marked other the any injury or other traumatic event, ITE computer specialist 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Herman Danford Blondell Wyatt ၉ 19a. Informant's Name/Relationship (Type. Print) Kathleen M. Danford/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 79 Club House Dr., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Salisbury Crematory 10/27/09 Salisbury, MD 4 Donation 5 Dother (Specify) Storalum of Funeral Service Licensee Thorieway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DRMANTIA **Physician** /Medical Due to (or as a consequence of): Examiner AKINSON DISRASR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Day Year signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Ho SPI CR 21 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after deatl Pruneral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician:

Medical To the within 2 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hunga 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and the of certifier

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and manner stated.

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

73

29c. License number

29d. Date signed (Month, Day, Year)

ms 2/102

36363 State of Maryland / Department of Health and Mental Hygiene [] [] 9 For State Registra Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Day **Physician** Year Αм 10 26 2009 Margaret Dykes 8:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anchorage Nursing & Rehab. Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Director 4-17-1917 Maryland 212-10-0205 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23s or 28s-f ahow the Medical Examinar must be notified at 1X Yes 2 ☐ No MD Wicomico Salisbury Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 300 Lemmon Hill Lane Funeral 21801 death USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White δ 3 ♥ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Operator Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental F 27 is marked of traumatic ever permit. Pages 1 and 2 should be Deportment of Health and Mental Importent: If item 27 1e marked any injury or other traumatic events any injury or other traumatic events. ပ Beniamin Franklin Helen Smith Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trudy T. Day - Daughter 5561 Scottish Hi hlands Circle, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-29-2009 Salisbury, Maryland Parsons Cemetery 21. Signature of Fugeral Service L 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Emphysema 5 years /Medical Due to (or as a consequence of): Examiner ASCUID 10 years. Sequentially list conditions, any, leading to minestal cause. Enter Underlying Cause (Disease or injury that initiated execu-Due to for as a curisequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Year Day 4☐Pregnant at time of death signed by the a 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Ves 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed page certificate Division of Vital 1□ Yes 2 No or Attending Physicien: rector. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this luneral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours af
To the Funeral D
completely filled in To the Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) in he reh October 27 1 2009 DR. USHA NATESAN 1051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415-S. DIVISION SALISBURY MD 21804 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

2009

State of Maryland / Department of Health and Mental Hygien 00936364 For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles 5:05 am Futrovsky October 27. 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 559-34-0551 87 1922 Washington, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic event. The Modical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director North Chevy Chase Maruland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. 20815 U.S.A. 8805 Montgomery Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 120 Yes 2 □ No If Yes, Give Year or Dates: WW11 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 X No Specify Specify þ White. 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pearson's Pharmacy Pharmacist. 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be f Health and Menta Jennie Goldbera Henry Futrovsky 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11112 Pinion Court, N. Potomac, Maryland 20878 Fred Futrovsky - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State

One of the content of the conte Judean Mem. Gardens 10/29/2009 Olney, Maryland any injury 22. Name and Address of Facility Hines-Rinuldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee) Ho #1070 11800 New Hampshire Ave., Silver Spring, MD 20904 Nancom Approximate Interval Between Onset and Death 23a. Part 1. Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head firm. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MON 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? has e 2 page this certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Tes 2. No 1 Inpatient 2 ER/Outpatient Certification; To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospitel 1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier sell mi D38 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, M.D., 2401 Research Blvd, Suite 330, Rockville, MD 20850 31. Date filed (Month, Day, Year) 22. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2009

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36365 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Forchielli October 23, 4:16 am Gino A. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min. 90 Director 187-05-8903 July 29. 1919 New Jerseu Usual Residence of Decedent 10c. City, Town or Location show 10d. Inside City Limits if than "natural", or items 23a or 28a-f sho 1 □Yes 2 No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10813 Lockland Road 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 X No 9 Specify. WWII 3 ₩ Widowed 4 □ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Corporate Associations 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nazareno Forchielli Virginia Bovosi 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Lynn Kazerouni - Daughter 10813 Lockland Road, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/29/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signatura of Funeral Service Licensee MO1102 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buris Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş Pneumonia, Congestive Heart Failure, Hypertension. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed Chronic Obstructive Lung Disease, Fraility 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □ Yes of Vital 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of I or Attending P after death. Director: After Division (28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Hospital on 24 hours af e Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+ **D53367** October 23. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Shyamsundar Rajan, 9801 Georgia Avenue, Suite 117, Silver Spring, MD 20902

Registrar

State

31. Date filed (Month, Day, Year)

29

Registrar's Signature

		-	For State Registrar	State of Ma	ryland	d / Dep <i>Ce</i>	artment e ertificate	of Health <i>of Deatl</i>	n and Mer <i>h</i>		giene Reg. No		09	363	66
			Decedent's Name (First, Middle, Last)					2.	Date of De	Da	ıy '	Year	3. Time of Dea	
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	Examin	er	4a. Facility Name (If not institution, give	street and number)	inz	+01	4b. City, To	wn, or Location	n of Death		40	. County o	1 h	stor	
	Funeral		5. Social Security Number 6. Se		(In yrs. la	ast birthday) If Under 1		er 24 Hrs. 8.	Date of Bir (Month, Da	th av Year		9. Birthpl: Count	ace (State or Fo	reign
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	and w	1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation						10	d. Inside City Li	mits
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	ter dea	nue	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13	. Was Deceder If Yes, specify	nt of Hispanic (Cuban, Mexic	Origin? (Specify can, Puerto Ric	y Yes <i>o</i> r No an, etc.))-	14. Race Black	- America , White, e		
36	al", or t	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 XN If Yes, Give Year or Dates:	0		1 □Yes 2	No Speci	ify:			Specify: Blac	k		
9-0	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or ttems 23a or 28a-f show ant, the Medical Exant methor notified at	ted	15. Decedent's Edi	ucation		16a. Dec	edent's Usual (Occupation	nost of working			Kind of Bus	iness/Ind	ustry	
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7	lled w Hygier ther th	S	17. Father's Name (First, Middle, Last)			PIU	mber	18. Mo	ther's Name (F		Poc , Maidei)		
and	d be fi	o Be	Annanias Forema	an					ie Par				,		
Baltimore, Maryland 21215-0036	nd 2 should be filed within and Mental Hygiene. 27 is marked other than 'r traumatic event, the Mental Hygiene.	2	19a. Informant's Name/Relationship (7			19b. Mai	iling Address (S		mber or Rural R		er, City	or Town, S	State, Zip	Code)	
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ore	Pages 1 and the page 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State			position (Name ematory or other		Date			_ocation - 0	•		
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Bal	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once.		2. Signature of Emeral Service Licens	Tor!	E		^{22. Name and} Bennie Funera		·	7 W. lisbu					
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death									Approximate Interval Betwee	
	Physician		Immediate Cause (Final disease or condition	L V o CA	RDI	IAI	INFAR	CTIEN						Onset and Deat	th
	/Medical Examiner		resulting in death)	Due to (or as a	a consequ	uence of):	s)	12112	6						
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0,	exec an an	Еха	resulting in death) Last	Due to (or as a	consequ	uence of):	1.								
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803 BOX	death certif e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at			B ☐ Ectopic pre D ☐ Other <i>(spe</i>					Mor		Day Yea	.r
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935 935	sician: Th certificate rector, pag	Be Co	25. Was case referred to medical					26. PI	lace of Death (1 □Yes Check only		10 1	Li tes	2 L1N0	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ys Sign		examiner? 1 ☐ Yes 2 █ No		^	€R/Outpat	ient 3 🗆 DOA		Nursing Home					ý)	
12/2/20 n of	ding Ph h. After th funeral	.uo	27. Manner of Deat 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry y, Year)	28b. Time Injur	of 28 y M	c. Injury at Work? 1 □ Yes 2		d. Describe	how inj	ury occurre	ed		
mes E 20 27 Division	Attending er death. rector: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be		ırv - At ho	ome, farm.				f. Location	(Street	and Numb	er or Rura	al Route Number	Γ,
James De 3 Divis	5 축 중 든	Certification: To	4 ☐ Homicide determined	building, etc	c. (Specif	(y)	,			City or To	òwn, Sta	ite)			
	• Hospital or Attend 24 hours after death • Funeral Director: letely filled in by the		(Check only 2 Medical Exam	ysician: To the best	f examina	owledge, de ation and/or	ath occurred a investigation,	t the time, dat in my opinion,	e and place, ar death occurred	nd due to the	e cause e, date a	(s) and ma ind place, a	nner as s	stated. the cause(s)	
ME	To the Hos within 24 hα To the Fun completely	Medical	one) 29b. Signature and title of certifier	and manner sta			29c.	License numb	per 77		29d. [Date signed	(Month,	Day, Year)	2
E	- × - ō		· W-	fory			(287	48		1	10-	23	-260	1
H	Dorl		30. Name and address of person who	completed dause of d	leath (Iter	n 23a) (Typ	e, Print)	(0 0	0 10	1/41	0-	-13-	110	218/1	/
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			1. Decedent's Name (First, Middle						2. Date of Death Month		3	3. Time of Death
	Physici: /Medic		Thoma:	Jose	ph_G	arafol:	a		October		909	4:59 P. ^M
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of Death		4c. County of	Death	
			Shady Grove Ad				Rockv	ille If Under 24 Hrs.	0 D-1 4 D'-1-		gomer	
	Funeral Director		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.		Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ear)	Country,	
			075-26-9566 Usual Residence of Decedent		7	0			July 20,	1933 1	New Y	ork
	ylanc		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d.	Inside City Limits
	e Mar	ctor	Maryland Mont	gomery		Gaither	sburg					1 ☐ Yes 2 X No
	e filed within 72 hours after death with the Maryland all Hygiene. all Hygiene. alchet than "natural", or items 23a or 28a-f show yent, the Medical Examinar rolat be notified at	Directo	10e. Street and Number				10f. Zip Code		10g.	. Citizen of Wha	at Country	?
	ath w		20731 Sabbath C				20882			United	Stat	es
	er de	Funeral	11. Marital Status	Armed F		l.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black, V	American White, etc.	Indian,
36	rs afte	by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ∐ Yes If Yes, G Year or I	2[∏No live		1 □Yes 2 🙀 No	Specify:		Specify:	Whi	+-
ခို	tural	ed	15. Deceden		Jales.	16a. Dece	dent's Usual Occup	ation	161	b. Kind of Busir		
212	in 72 in "ine Medic	plet	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of work done o	furing most of work	ina	U.S. De		,
77	d with giene gr tha	Completed	Elementary/Secondary (0-12)	2		Mea	at Grader			Agric		
g	be filed within 72 hours after death with the Marylan Hygione. Id althylian "natural", or items 23a or 28a-f show the Hygione. If a Madical Examinar must be notified at	Be (17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle, Mai	iden Surname)		_
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a	es 1 and 2 should be fit of Heatth and Mental H f item 27 is marked oth r other traumatic even		19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Number or Rur	al Route Number, C	ity or Town, Sta	ate, Zip Co	ode)
≥ o`	of Health of Health litem 27 I		Claudia B. Gara	fola/Spou					aithersbu			
Baitimore, Maryland 21215-0036	permit. Pages 1 Department of I Important: If ite any Injury or ot once.		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation	3 Removal from	State		sition (Name of natory or other plac	i		c. Location - Cit		
	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (S		Nor				0/2009 0		aryla	ind
a R	Depa Impo any I	-	21 Signature of Funeral Service	Licensee	2 a V. (10			ol Funera		100	22277
÷		-	23a. Part 1. Enter the disease, or	complications that	caused the deat				r., Gaith			2U8//
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.		or the mode or dyin	g, such as cardiac	or respiratory arrest	,	Init Or	terval Between nset and Death
	Physician /Medical		disease or condition resulting in death)		onary En						Mi	Inutes
	Examiner				ılar Dis						De) T. G
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq						De	ıys
	cuted	Examiner	Cause (Disease or injury that initiated events	. Amyot	rophic	Latera	1 Scleros	sis			Ye	ears
Ď,	e exe ian ar ırial-t		resulting in death) Last	Due to	(or as a consec	quence of):						
8/60,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d								
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Ž Q	attend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	tcome of pregn birth 2 Feta	aldeath 3	Ectopic pregnancy	/		23d. Date of		y Year
j	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 □ Unk	gnant at time of one of the second of the se	death 5L	Other (specify)					,
7.	that the the control of the control		Part II. Other significant condition	ons contributing to o	feath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribu	ute to the o	ause of death?
g	uires 1 sign 1d be	d b							1 ☐ Yes	2 □ No 3[☐ Probabl	y 4X Unknown
cords	w req	ete							24a, Was an	24h We	re autonsv	findings available
ŭ L	he lar e has age 2	Completed							autopsy performed	d? pric	or to completh?	etion of cause of
	an: T	0	25. Was case referred to medical					26 Place of Death	1 ☐ Yes 2 ☑ h (Check only one)	§No 1 L	Yes 2	□No
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5	ig Ph ter th	Certification: To	27. Manner of Death	28a. Date		28b. Time of		/ at	28d. Describe how i		(Opoony)	
ion i	endir ath. or: Af he fur	atic	1X Natural 5 ☐ Pending investig	ation	m, buy, rour,	,.,		res 2□No				
S	or Att	≝	3 Suicide 6 Could r 4 Homicide determ	ned 28e. Plac	e of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		or Rural Re	oute Number,
ָׁ	ral o	- 1	l	341								
:	to the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 ☑ Certifyin (Check only one) 1 ☑ Certifyin 2 ☐ Medical	Examiner: On the	basis of examina	owledge, deatl ation and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and mann and place, and	er as state d due to the	ed. e cause(s)
,	thin 2	Med	29b. Signature and title of certifier		nner stated.		29c. License	number	294	Date signed (//	Month Day	(Year)
				1/	A.		D(17093				
	10	}	30. Name and address of person	who completed car	se of death /Itos	n 23a) (Time	Print)	(101)	00	tober 2	26, 2	009
			Martin McGreiv	(, , ,, ,		ive. Rock	ville. Ma	rvland	2085	0
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	Registra	ır	OCT 29 2	009 Den	un B	par						

State of Maryland / Department of Health and Mental Hygiene 36368 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:25 a M Ezzat Golnavaz 22 10 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/15/1939 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F 69 **Director** Iran 220-47-6068 Usual Residence of Decedent f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Workeal Eventimes at the Modeal Eventimes in the notified at 1 ☐ Yes 2X No Director Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 342 Tannery Dr. 20878 Iran Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ∐Yes 21X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. I **other than**"ı Elementary/Secondary (0-12) 12 College (1-4or 5+) Technician Medical Healthcare permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked ofth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abass Golnavaz Narjess Shadalooie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roozbeh Saffari 342 Tannery Dr., Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial 10/26/09 Rockville, MD 21. Signafure of Funeral Service Line 22. Name and Address of Facility Universal Mortuary Inc. Kennedy St NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** T-cell lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Colon cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): death certificate be executed and -trans Due to (or as a consequence of): burialphysician s the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) o 1 ☐ Yes 2 No 9 Unknow detach þ ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Tuberculous lymphadenitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) Hospice Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 29a, Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hot To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1. Kouestehou D63748 10 / 22 / 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, MD 6001 Muncaster Mill Rd, Rockville, MD 20855 32. Registy 's Signal State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 36369 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 10/23/2009 **Physician** 1830 Vincent C. Gray Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cheverly Prince George 5. Social Security Number If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex Funeral 1**X** M 2□ F Months Days Hours Min. 1^{(Month}201 924 578-20-2611 Director 85 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c, City, Town or Location 10a State 10h. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Medical Ext. uppr must be notified at once. Director 1 XYes 2 No Maryland Prince George Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20613 13624 Tower Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Janitorial Shopping Centers 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edelen Rosetta Gray ဥ Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13624 Tower Rd, Brandywine, MD 20613 Helen E. Gray 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/31/09 Clinton, MD 4 Donation 5 Other (Specify) Resurrection 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA, Aguasco MD 20608 MO1589 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hypoxemia Due to (or as a consequence of): Box 68760, or Attending Physician: The law requires that the death certificate be Acute Renal Failure Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 \(\textstyle{1}\)No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation eral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number MD52855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Deine Cheverly, MD Registrar's Signature 31. Date filed (Mor

DHMH 17 Rev 1/2001

State Registrar Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Examine Funeral Director		4a. Facility Name (If not inst 7515 DEVILLE 5. Social Security Number 215–26–2951	COUR 6. S			(In yrs. l	ast birthday) Yrs.	UPPER MA If Under 1 Year Months Days	ARLBO	ORO ler 24 Hrs.	8. Date of Bi (Month, D	PR PR: rth ay, Year)	INCE GEO HNGE -GEO 9. Birtt	ORGE! S	_
r the Maryland r 28a-f show	irector	Usual Residence of Deceder 10a. State	ounty	George's			, Town or Lo					10g. Cit	izen of What Co	10d. Inside Ci 1 XYes untry?	•
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permit. Pages Department of Important: If Its any injury or o	ļ	1 Burial 2 Crema 4 Donation 5 Ott 21. Signature of Eune LSe	er (Speci	ify)	State	C	emetery, cře. surrec	natory or other pla		10/31 cilityPope	/2009 Funer	Cli	nton. Ma	ryland	
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nyslcia his certi I directo	To Be	25. Was case referred to m examiner? 1 ☐ Yes 2 ☐ No	euicai	Hospital: 1 🗆	Inpatien	t 2 🗆	ER/Outpatie	nt 3 L DOA	her: 4 🗆				6 ☐Other (Spe	cify)	
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To th withir To th comp	Me	29b. Signature and title 90c	ertifier	· N	ll	, L <i>v</i>	139	29c. Licen			Marylin		ate signed (Mog	h, Day, Year)	
28		30. Name and address of p		•		•			Mar11	horo	Marv12	nd 2	0772		
Sta Registra		31. Date filed (Month, Day OCT 2 9 20	Year)		Registrar	's Signa	iture		LUL LI		····· y La		<u>.</u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36371 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 24/2009 Comillus 0330 S. Harley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern MD Hospital Prince George <u>Clinton</u> Age (In yrs. last birthday) Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Davs Hours Min. 2^{Mg}nth, Pay, 3°201 WashingtonDC Director 213-40-7258 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1 X Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P "natural", or items 23a or edical Examiner must be Funeral 13523 Holly Spring Dr 20601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian. Armed Forces?
Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Completed Black Year or Dates th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) District Government Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Iola A. Harvey permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. John M. Harley Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Harley/Wife 13523 Holly Spring Dr.Waldorf MD 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State St.Peters Ch 10/29/09 Waldorf MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1589 Adams Funeral Home PA, aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interction Myourdin Onset and Death Immediate Cause (Final Physician/ 1531VC Μ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE r use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No s been signed by the sign should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsv 2 🗌 No certificate 1 🗌 Yes Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 2 🗹 No မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 M ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0064055 10125/00 ~> ~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

7503

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egistrar's Signature

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OCT 282009

		State of Mary - State Registrar Amended#18perFH FCHD, F	rland / Depa KS <i>Cei</i>	artment of He rtificate of D	ealth and M Leath 11/	1ental Hygie: 2 /09	ne 2009	36372
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Funeral Director		214347195 1⊠M 2□F 7	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Co	hplace (State or Foreign untry) ington D.C.
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death	Funeral	1070 Long Corner Road 11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	217 Was Decedent of His If Yes, specify Cuban		ecify Yes or No-	U.S 14. Race - Ame	rican Indian,
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal matter traumatic event, the Medical Examinal matter traumatic and once.	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion Iring most of work	ing 16b	. Kind of Business/	Industry
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1 and Health em 27 ther tr		Dorothy L. Hill - Wife 20a. Method of Disposition					Lry, Mary	1and 21771
Pages nent of int: if its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donates 5 ☐ Other (Specify)		osition (Name of matory or other place, ve Cemete				, Maryland
permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee) <u>2</u> 2	2. Name and Address	of Facility -Williams	5 P.A., F1	meral Ho	me
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Physician		Immediate Cause (Final disease or condition resulting in death) a. Aut Mylle's 8	enus Leuken	лій				Onset and Death
Medical Examiner		Due to (or as a co						> 5 yeurs
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ertifica ling ph e as th	Med	IF FEMALE:						
To the Hospital or Attending Physician: The law requires that the death certifications after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year
s that t	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the u	ınderlying cause giver	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
equire sen sig ould b						1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
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ig Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatie	III 3 LI DOA	4 LI Nursing Ho	ome 5 Residence 28d. Describe how i		ecify)
tendir leath. tor: Af the fur	catio	2 Accident investigation		M 1 □Y	es 2 □No			
tal or Al s after c al Direc ed in by	Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (8	- At home, farm, st Specify)	reet, factory, office		28f. Location (Stree City or Town, S	it and Number or R itate)	ural Route Number,
ne Hospil n 24 hour ne Funer oletely fill	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of example and manner stated	amination and/or in					
To th To th	M	29b. Signature and title of certifier		29c. License			Date signed (Mon	th, Day, Year)
			/la 00-1 /T		C 1 15]	1	0/25/09	
		30. Name and address of person who completed cause of death NIKHIL PATEL , 22.5. Greens + , BUITY	HUR, MID 21.	wi				
Sta Registr		31. Date filed (Month, Day, Year) OCT 27 2009 32. Registrar's	Signature A. A	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1 Month 2^{Day} 200^{Yea} **Physician** ANNA **BOWERS** HOLLOWAY 6:05 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number)
ALICE BYRD TAWES Examiner SOMERSET CRISFIELD NURSING HOME

5. Social Security Number

6. Sex If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2X F MAŘÝĽAND 212-20-6431 88 DEC.9,1920 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County Items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 ☐ No MARYLAND SOMERSET CRISFIELD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number AMERICA 21817 STATE ROAD 26552 OLD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc Examiner 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No SpecifWHITE Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No þ 3√ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical COUNTY GOVERNMENT than, Elementary/Secondary (0-12) College (1-4or 5+) CLERK the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H 7 is marked otl VIOLA DULIN permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev CLARENCE HARRY RICE 19b. Mailing Address (Street and Number of RUA) Boute Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) FRANCES A. MAHONEY DAUGHTER CRISFIELD, MARYLAND 21817 OCT. 27, 2009 CEAFORD DEED 20b. Place of Disposition (Name of cemetery crematory or other place)
ODD FELLOWS 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SEAFORD, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 21. Signature of Faneral Service Licersee 2WATSON-YATES FUNERAL HOME, INC. 19973 FRONT & KING STREETS SEAFORD, DE. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC COLON CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached f 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: Hospital: 2 ER/Outpatient 3 DOA 1 TYes 2 No 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 43298 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALL HIGHWAY, CRISFIELD MD 21817 VIJAY KARUMBUNATHAN, 201 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State 2009 Lensura Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year KENNETH **Physician** WAYNE JENKINS 02-03PM OCT 23 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth NOV • 9, 1947 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F Washington DC 577-64-2287 61 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 28a-f show s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene then free 17 st marked other than "natural", or items 23a or 28a.f show other traumatic event, the Medical Evanture must be milliad at other traumatic event, the Medical Evanture must be milliad at 1 ☐ Yes 2 No Maryland Harwood Director Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4748 E. Flanders Lane 20776 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐Yes 2 X No Black, White, etc. 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 □Yes 27 No Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Jenkins Violet Louise Click ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4748 E. Flanders Lane Harwood, Maryland 20776 M. Hannah Jenkins -wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition permit. Pages 1
Department of IImportant; If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 10/25/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final INTRACEREBRAL BLEED Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, issuing to humbolists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a consectionor of: Examine Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed ENDSTAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed/ 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTOBER 24, 2009 MA 0062634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA MO 21044 10802 HICKORY RIDGE RO MATEEN AWAN 31. Date filed (Month, Day, Year) 3. Registrar's Signature State

DHMH 17 Bev 1/2001

Registrar

OCT 29 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ralph N. Joseph Sr. 0541A M 2009 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kninsula Kecional Medical TalishU14 lente, WICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1-14-1930 9. Birthplace (State or Foreign Country) Delaware 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months 1 M 2□F Days Hours 221-18-2220 79 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Expurient must be multified at 1 ☐ Yes 2 No Director DE Sussex Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with 19956 12347 Whitesville Road USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 12 Yes 2 □ No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: White 1 □ Yes 2 No Specify: If Yes, Give Year or Dates: ģ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If item 27 Is marked other than Injury or other traumatic event, Item Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Joseph Blanche Whaley ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Joseph, Jr. (Son) 34444 Old Stage Rd. Laurel, De. 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury o Laurel Hill Cemetery: 10-23-2009 Laurel, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 700 West Street 22. Name and Address of Facility Signature of Funeral Service Licensee Hannigan, Short, Disharoon F.H. Laurel, De. 19956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** letasta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading of including cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the attending potential to the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 0 ☐Yes 2☐No be detached 9 Unknown 9 Unknown signed by σ. The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 - No 1 ☐ Yes To the Hospital or Attending Physician: 'within 24 hours after death.'

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AVIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL ST. SAlisbury Md 21801 CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State barke Registrar

1- For Amend Items State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** WILLIAM EMMETT JENKINS 19 2009 3:45 AM October /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Harford 4444 Graceton Road Pylesville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 1 / 12 / 19 3 3 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday Funeral 1 🔀 M 2 🗆 F 164-28-6039 76 Director Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a State 28a-f show traumatic event, the Medical Exacting count be notified at MD Harford Pylesville 1 □Yes 🎗 🗆 No Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 21132 4444 Graceton Road items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ ss 2 ☐ No If Yes, Give Year or DatesKoreaEra 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 X No Specify White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) Over Head Supervisor Utility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berna Scarborough Charles Morgan Jenkins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Betty Jenkins/Wife 4444 Graceton Road, Pylesville, MD 21132 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 10/22/2009 New Park, PA Centre Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funded Service License 22. Name and Address of Facility Harkins Funeral Home, Delta, PA 17314 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** chini remo 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner High Blood Pressure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the Division of Vital Records, P.O. detached 9 I Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation **√** Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D32255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MacPhail Road, Bel Air, MD 21014 12 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 2 2009 Darke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 36377 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:00 pm Lillian Kessler 26, 2009 October /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours 578-32-7986 July 10, 1926 South Carolina Director 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 5450 Whitley Park Terrace 23a 20814 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? or items 14. Race - American Indian, 11, Marital Status within 72 hours after 1 ∐Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 2 White 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within and Mental Hygiene.

s marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If item 27 is marked othn any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Max Wolper Tillie Bordack ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Kessler - Daughter 528 12th Street. NE. Washington, DC 20002 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/28/2009 | Olney, Maryland Judean Mem. Gardens 21. Signature of Funeral Service Licensee Ho #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, MD20904 23a. Part 1. Enter the dilease, shock, at Land 1886 re. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, than, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Stroke Due to (or as a consequence of): signed by the attending physician be detached for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 icate has been si Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifie 1 🗓 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66264 October 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd., Bethesda, MD 20814 Babak Pirouz. 31. Date filed (Mortth, Day, Year) State

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Registrar

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To the Hospital or Attending Physician: The taw within 24 hours aller death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director; page 2	ertification; To	1 Inpatient 2 EN/Outpati	of 28c. Injury at 28d	esidence 6 ⊡0the. Describe how injury occurr	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f.	Location (Street and Numb City or Town, State)	er or Rural Route Number,
the Hospi in 24 hou the Funer pletely fill	edical		ath occurred at the time, date and place, and investigation, in my opinion, death occurred :	due to the cause(s) and ma at the time, date and place, a	nner as stated. and due to the cause(s)
Vith To To	2	29b. Signature and title of certifier Albary Hohres MD DME	29c. License number D37/97		1 (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type Han Konsew, MDDMF 15 West	Print) th Street, F.	redevick.	MD 21701
Regi	State strar	31. Date filed (Month, Day, read V 1 2 200 Gegistra Signature	1. Spark		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36380 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Physician 12:05 PM 2009 I. KULAKOVA MARIYA NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANIDALLSTOWN SEA SONS HOSPICE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 😿 F 216-79-895 OCTOBER 6 4551A Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Modical Examination motified 1 □Yes 2 No Director BALTIMORE LUTHERVILLE W D 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number MORRIS 21093-4916 R 4551A 604 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE <u>≨</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOMF OMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAPOUN IKOUA KULAKOV MATRENA VAN ဂ္ permit. Pages 1 and 2 should Department of Health and Mu Important; If Item 27 is mark any Injury or other traumati once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \$1093 19a. Informant's Name/Relationship (Type. Print) NEPOLNYASHCHAYA LUTHER VILLE, MO 604 MORRIS AUE. ANASTASIYA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 128urial 2 Cremation 3 Removal from State HOLY TRINITY ORTHODOX NOU. 7. 2009 ELKRIDGE MD 4 ☐ Donation 5 ☐ Other (Specify) CANBY 22. Name and Address of Facility 6009 HARFORD ROAD JOSEPH M 000 78 MARZULLO FUNERAL CHAPEL BALTIMORE, MO SISIH 23a. Fa M. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Due to (or all a consequence f): Physician Fally ase or condition resulting in death) /Medical Examiner Polmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami POPED BY MEDICAL EXAMPLES Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death CERTIFIC 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 No 1 ☐ Yes 2 Mo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Specify NS 1+0SPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XYes 2 No Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Fall death. 1 ☐ Yes 2) ☐ No 2 Accident 10/20/09 Unknown 24 hours after deat Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (004 Morris Avenue, Lutterville MI 604 Morris Avenue zithonille, MI ca 29a. Certifier 1🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 2 2009

DHMH 17 Rev 1/2001

5401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mon

Registrar's Signatur

HYS 931

OLD COURT ROAD RANDALLSTOWN MD

November 4 2009

Phy:	sician
/Me	edical
Exa	miner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examinar must be rediffed at Baltimore, Maryland 21215-0036 Physician

/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar

	State of Maryland / E	epa Cer	rtmei	nt of H	lealth Death	and M	lental Hyg	giene,	2009	36381
	Registrar 1. Decedent's Name (First, Middle, Last)	001			Joann		2. Date of Dea	iog. 110.		3. Time of Death
n al	MARY D. LOXTON						OCT 2	_	009 Year	3:02AM [™]
er	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				SPRI				County of Dea	
ī	5. Social Security Number 6. Sex 7. Age (In yrs. last bird			er 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day JLY 30	<u> </u>	9. Bir	thplace (State or Foreign
	Usual Residence of Decedent			<u> </u>		- 0	<u>энт</u> эо	1 2 2		
_	10a. State 10b. County 10c. City, Town			D.F. D.G						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ည	MD. P.G. UP	PER		RLBC	RO			10a Citiz	en of What Co	
<u> </u>	13101 BARGEESE COURT		101. 2	207	74			Ü	JSA	,.
merc	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Dece Yes, sp	edent of H	ispanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)		4. Race - Am	
Be Completed by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:		□Yes		Specify		, ,		Specify: BL	
Led	15. Decedent's Education 16a.			ual Occup					nd of Business	
mple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. D	OO NOT	ork done i use retired RESS		it of worki	ng		PRIVA'	TE -
Š	17. Father's Name (First, Middle, Last)			TUDDE		er's Name	e (First, Middle,			
0 0	EARNEST DANIELS						H YOUNG		,	
							al Route Numbe			
	20a. Method of Disposition 20b. Place of				ESE		Date		CLBORO	MD. 20774
	1 ☐ Burial 2X Cremation 3 ☐ Removal from State R TVE 4 ☐ Donation 5 ☐ Other (Specify) CRE	ŔďA	${ m LE}^{or}$	PARK	(e)				ERDALE	
	21. Signature of Funeral Service Licensee	22	. Name a		ss of Facil	•				010
							14th	<i>'</i>	N.W.	1
	23a. Part1. Ehter the disease, or complications that caused the death. Do a state of the death interest. List only one cause on each line. Immediate Cause (Final	not ente	er the mo	ode of dyir	ng, such as	cardiac (or respiratory ar	rest,		Approximate Interval Between Onset and Death
	disease or condition resulting in death) a	of):	^							
_	Sequentially list conditions, b. Jevev M.		sc X.	C /	محرز کا	65.)			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) (Ca	lin	5					
dicai Examiner	resulting in death) Last Due to (or as a consequence									
dica	(d. <u>CO1175</u>	E	X (L	しり	2110	n				
n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy							2	23d. Date of de	elivery
Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 9 ☐ Unknown		Ectopic Other (pregnand specify) _	ý				Month	Day Year
P _n	Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying	cause giv	en in Part	l.	23e. Did to	obacco u	se contribute	to the cause of death?
o p							1 🗆 1	'es 2[□No 3□F	Probably 4 XUnknown
piete							24a. Was	an	24b. Were a	autopsy findings available completion of cause of
							perfo	rmed? 2 X lo	death?	s 2 No
De	25. Was case referred to medical examiner? Hospital: Hospital:			Oth	or:		h <i>(Check only</i> o		_	
2	27. Manner of Death 28a. Date of Injury 28b.	Time of		28c. Inju	y at		me 5 Residence Residence Residence 1			ecify)
all C	2 Accident investigation	njury	М	Wor 1 □	K? Yes 2□]No				
Certification: 10	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stre	eet, facto	ry, office			28f. Location (S City or Tov			Rural Route Number,
2	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only 2 Medical Examiner: On the basis of examination ar									
Medical	one) and manner stated. 29b. Signature and title of certifier				se number	30001				nth, Day, Year)
-	b or Shanding and the or certifier		-		66372	2			23 20	
	30. Name and address of person who completed cause of death (Item 23a)	(Type,	Print)							
	DR. MAJID RAHMANIAN 1500	FO	RESI	GL	EEN :	ROAD	SILVE	R S	PRING	MD. 20910
r	31. Date filed (Month, Day, Year) OCT 2 9 2009 Server 32. Registrer's Signification	200								

			For State Registrar	State of Ma	-	ertificate of		wentai ny	Reg. No. 200	9 36382
	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of De Month	Dav Year	
-	/Medic	al	E. Edward Los					Oct.	26 2009	8:40 A M
	Examin	er	4a. Facility Name (If not institution, gi	· ·			or Location of Death	٦	4c. County of De	
	Funeral		Union Hospita 5. Social Security Number 6.		(In yrs. last birthda	Elkton (ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th 9. B	rthplace (State or Foreign Country)
	Director		110-10-3568 Usual Residence of Decedent	1X M 2□ F	96 Yrs	Months Days	Hours Min.	July 2	12, 1913	Maryland
	show	or	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 No
	the N 28a-1	rect	Maryland Cecil 10e. Street and Number		Chesa	peake City			10g. Citizen of What C	
	3a or	Ö	402 Biddle St.				21915		USA	outiny:
	ms 2	nera	11. Marital Status	12. Was Decedent E	ver in U.S. 1	3. Was Decedent of I If Yes, specify Cub		pecify Yes or No	- 14. Race - Am	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Invited Evantment rust be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	0	If Yes, specify Cub 1 ☐ Yes 2X No		o Rican, etc.)	0	white
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr		16a. De	cedent's Usual Occu	pation	kina	16b. Kind of Busines	s/Industry
121	ne, han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	ive kind of work done e. DO NOT use retire		Kilig		
22	lled w Tygie ther ti	S	12 17. Father's Name (First, Middle, Lasi	1	Mar	ina owner/	1	ne (Eirot Middle	Marina , Maiden Surname)	
ano	d be f ental l red of	Be c	John Losten	/				Petrysh		
Maryland	should nd Me mark imarti	၉	19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ailing Address (Street		-	er, City or Town, State,	Zip Code)
ž	alth a 27 is 27 is strain		Bishop Basil Lo	sten/Broth	1	Peveril R				•
Z.	es 1 a of He of He rothe		20a. Method of Disposition			sposition (Name of rematory or other pla		Date	20c. Location - City o	
<u>=</u>	Page ment ant: II		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			e of Lima	Cemetery	0-2009	Chesapeake	city, MD
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Li	1		R.T. Foa	ess of Facility rd Funera	1 Home,	P.A. ke City, M	112
	tificate be executed Weddical By Aman Amanata As the burial-transit As the burial-trans	ledical Examiner	23a. Foot, Enter the disease, or consolon, or heart failure. List only interest cause in a lisease or condition resulting in de unit of the cause. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c.		N PNCLLM				Approximate Interval Between Onset and Death
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other <i>(specify)</i> _	су		23d. Date of d Month	elivery Day Year
Division of Vital Records, P	uires that signed b	ē	Part II. Other significant conditions	contributing to death bu		e underlying cause gi	ven in Part I.		obacco use contribute Yes 2 □ No 3 □ I	to the cause of death?
Ö	w req	lete		CARCI NO				24a. Was		autopsy findings available
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ita	ctor, p	Be C	25. Was case referred to medical examiner?	+			26. Place of Dea	th (Check only o	one	
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is i	al or Attend after death Director: / d in by the fi	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Inju	ry - At home, farm,	street, factory, office]Yes 2□No	28f. Location (Street and Number or I	Bural Boute Number.
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	ne Hospit n 24 hour le Funera pletely fille	Medical (29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	nysician: To the best o miner: On the basis of and manner stat	examination and/or	eath occurred at the t r investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
	Vithi To th	ž	29b. Signature and title of certifier	. 1		29c. Licen		a de la companya de l	29d. Date signed (Mor	nth, Day, Year)
			P.V. Noge	> n	D	Do	0065733		10/26/19	
(6		30. Name and address of person who	V. PULA	126	Print) F. 1416H	smeet,	ELKT	ON, MD 21	921
	Stat Registra	~	31. Date filed (Month, Day, Year) OCT 2 9 2009	32. Registra	r's Signature					-

State of Maryland / Department of Health and Mental Hygiene 2009 36383 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT. 22, Day 2009 Year **Physician LEONARD** GARFIELD MYERS, SR 3:00 р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONIGOMERY 17428 Hoskinson Road Poolesville 8. Date of Birth (Month, Day, Year) July 26,1933 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min ty☑ M 2 ☐ F 76 Director 215-28-4445 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at any injury or other traumatic event, the Medical Evantiner must be notified at any injury or other traumatic event, the Medical Evantiner must be notified at any injury or other traumatic event. Director MD Montgomery Poolesville 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17428 Hoskinson Road 20837 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

12. Was Decedent Ever in U.S. Armed Forces?

12. Value of the control of the con Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Dyes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) yrs Real Estate Agent Weichert Realtors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Elizabeth Cook Leonard Eugene Myers ဂ္ 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Myers (Wife) 17428 Hoskinson Road, Poolesville, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Zion Church Cem 10/31/09 Brookeville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Recurrent **Physician** Jupras latic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A letely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Oct 23, 2009 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) 3416 Olandwood Ct, Ste 200 Olney, MD 20832 EVELYN 504 31. Date filed (Month, Day, Year) State 29 2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 **Physician** Month Oct. 26, 1:40 P. M MEYERSON /Medical Ann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 5225 Pooks Hill Rd. #1801South Bethesda 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1927 New Jersey If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 □ M 2 🕱 F 150-20-0377 Director 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it is madical Examinan must be redified at 1 □Yes XXNo Bethesda Director Md Montgomery 10f, Zip Code 10a, Citizen of What Country? 10e. Street and Number 20814 U.S.A. 5225 Pooks Hill Rd. #1801south death \ Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the tot Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 □XNo Specify Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) own home 4 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther Schuster Shapiro ပ Jacob 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 Statton Drive, Potomac, Md. 20854 Jann Sidorov/ daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot Judean Memorial Gard. Oct. 29,2009 Olney, Md. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licenses 21 254 Carroll St., N.W., Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): 10 vears Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 10 years Hypercholestral The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☒No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Peripheral Vascalar Disease 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform performed? 1 □ Yes 2 🖾 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical mipletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

(10

29b. Signature and title of certified

30. Name and address of per on vino completed car John A. Ga otto, MD

31. Date filed (Month, Day, Year) OCT 29 2009

2. Registrar's Signature

29c. License number D0011921

of death (Hem 23a) (Type Print) 5225 Pooks Hill Rd., #1A, Bethesda, Md 20814

29d. Date signed (Month, Day, Year)

Oct. 27, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36385 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** /Medical 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Nov. 30, (In yrs. last birthday, **Funeral** 1 □ M 2 🕇 F Months Days Hours Min. 1915 069-12-0247 93 Germany Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be positived at Director 1 ☐ Yes 2X No Maryland Bethesda Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8217 Maple Ridge Road 20814 USA Funeral be filed within 72 hours after death ntal Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify þ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Delicatessen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franz Lademann Christine Nansen ၉ . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8217 Maple Ridge Road, Bethesda, MD 20814 19a. Informant's Name/Relationship (Type. Print) Elke Carla Meldau—Womack/ Daughter Pages 1 and 2 s ment of Health ar 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation Date 20c. Location - City or Town, State October 29, Department of Important: If it any Injury or conce. 3 Removal from 2009 Alexandria, Virginia 4 ☐ Donation 5 Cther (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Se Ligensee 23a. Part . Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner nukronn Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗆 No 1 □ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To this ð 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending Provibin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated

State Registrar

29b. Signature and title of certifier

JarlaF.Mel

cause of death

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 36386 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Constance Lee Mitchell 4:40 AM 10 19-/Medical 2000 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at Salisbury Wi comico the Like If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F 220-52-0180 Director 61 Mar 29, 1948 MD Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f sho event, the Middal Exam the motified at Director MD 1 Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 West Road 21801 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married African-1 ☐ Yes 2 📉 No Specify. 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Various Factories Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Menta item 27 Is marked Benjamin Rider Katherine Polk Department of Health and Mer Important: If item 27 Is marke any Injury or other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernetta Mitchell/daughter 1004 West Road, Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Balisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10/28/09 Salisbury, MD 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Lewis N. Watson Funeral Home, PA Talana p Cassor 1618 West Road, Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARREROVASCHUA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 certificate has been signed by the attending physician ector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Q Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No. 9 Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 24 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 □Yes 1 TYes To the Hospital or Attending Physician: within 24 hours. fler death.

To the Funeral Infrector. After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) Other: 4 Nursing Home 5 Residence Characteristics Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To HOSPICIZ 27. Manney of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier **Medical** and manner stated.

State Registrar 29b. Signature and title of certifier

Citaryon WARY

31. Date filed (Month, Day, Year) OCT 27

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DASTAL

Seneur

32. Registrar's Signature

HOSPICE

D005 8410

29d. Date signed (Month, Day, Year)

~ BOX 1733 String un 21802

			Plea For State Registrar	State of	Maryland /	Depa <i>Cer</i>	rtment of b tificate of	. Ensure Health an <i>Death</i>	d Mental I	es Are Hygier Bea. N	e Legib	1e. 0 9	36387
	nysicia Medic		1. Decedent's Name (First, Middle	le, Last)	:Cool				2. Date of	Death	21, 20		3. Time of Death 3:32 pm
	xamin		4a. Facility Name (If not institution 1115 Quiet Acr		ber)		4b. City, Town, c	r Location of D	eath	4	c. County of	Death)
	neral ector		5. Social Security Number 246-52-5911	6. Sex 1 □ M 2 X F	7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Ain (Month	Birth Day, Yea	38	Count	ace (State or Foreign ry) ch Carolina
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s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hydiene.	Examiner mu	by Funeral	11. Marital Status 1 Nover Married 2 Marr 3 Widowed 4 Divorced	ried 1 Tyes 2	2 X No e	- 1	Vas Decedent of H FYes, specify Cub	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or uerto Rican, etc.	No-	14. Race Black, Specify:	White, et	
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and 2 should be lealth and Mental	r traumat		19a. Informant's Name/Relations George - Ann		personal 19	b. Mailin 299	g Address (Street	and Number o	r Rural Route Nu	imber, Cit	y or Town, S	itate, Zip	Code)
permit. Pages 1 an Department of Heal	or othe		20a. Method of Disposition 1 ☐ Burial 2 【★Cremation				sition (Name of natory or other pla		Date 0/27/09		Location - C	•	
mit. Pa	y Injury		4 ☐ Donation 5 ☐ Other (S		Salis		Name and Addre	- Y			alisbu		sociation
	a d		200 Part I Esta the disease	Glan	el	50	Ol Snow	Hill Rd	., Salis	sbury	, MD 2	21804	ł
Physi	ician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on ea	idsed the death. Do	not ente		phom		ry arrest,			Approximate Interval Between Onset and Death
/Med Exan	dical niner	:	resulting in death)	Due to (c	or as a consequence	of):			•				
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.	ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bi	ome of pregnancy irth 2□Fetal deat ant at time of death own] Ectopic pregnan] Other <i>(specify)</i> _	су			23d. Date Mon		ry Day Year
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VILC /sician	lirector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2 ☐ ER/C	utnatien	nt 3 DOA Ot	26. Place of her: 4 🗆 Nursi	Death (Check o		6 □ Othe	r (Cnasih	4
nding Phy ath.	e funeral c	ation: To	27 Manner of Death 12 Natural 5 Pendin 2 Accident investig	28a. Date o (Monti	-	Time of Injury	28c. Inju Wo		28d. Desci		njury occurre		7
safter des	ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could determ	nined 28e. Place	of Injury - At home, t g, etc. (Specify)	farm, stre	eet, factory, office		28f. Locati City o	on (Street r Town, St	and Numbe ate)	r or Rura	l Route Number,
e Hospil	oletely fill	Medical (29a. Certifier (Check only one) Certifyir 2 Medical	ng Physician: To the I Examiner: On the ba and mann	isis of examination a	ge, death and/or in	h occurred at the vestigation, in my	ime, date and popinion, death	place, and due to occurred at the t	the caus ime, date	e(s) and mai and place, a	nner as st nd due to	tated. the cause(s)
vithir	сош	Me	29b. Signature and title of certifie	-//	1/2 //	M	29c. Licen	se number	7 75	29d.	Date signed	(Month, I	Day, Year)
1	AI		30. Name and address of person	who completed cause	e of death (Item 23a)) (Type,	Print)	0 60	70	7 /	1/	1	0164
حي	<i>V</i> Sta	te	31. Date filed (Month, Day, Year)		Pastal Ho egistrar's Signature	5/14	e po	150× 17	+13 S	alis	h	M	21802
R	egistr		OCT 2	6 2009	Envera &	1. 14	barke				0		

36387

B Division of Vital Records, P.O. Box 68760

			For State Registrar			Certificate of			Reg. No. 200	
	Physici		Decedent's Name (First, Middle, La ELEANOR D.	,				2. Date of De Month OCT 2	24, ^{Day} 2009 Yea	3. Time of Death 6:21 A M
	/Medic Examir		4a. Facility Name (If not institution, give	e street and number)			r Location of Death	1	4c. County of D	eath
	Funeral		Shady Grove Adve		ltal (In yrs. last birtl	Rockv	If Under 24 Hrs.	8. Date of Bir	MONTGO	Birthnlace (State or Foreign
	Director		218-24-1074 Usual Residence of Decedent	1□ M 2□ x F	83	rs. Months Days	Hours Min.	Apr.	9, 1926 1	Country land
	yland		10a. State 10b. County		10c. City, Town	or Location	-			10d. Inside City Limits
	he Mar 28a-f s	ecto		tgamery		Gaithersb	urg			1X Yes 2 ☐ No
	3a or 2	I Dir	10e. Street and Number 108 Harmony Hal	ll Road		10f. Zip Code 20877			10g. Citizen of What U.S.A.	Country?
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race · A Black, Wl Specify: I	
15-0	"natur	letec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	oation during most of work	ing	16b. Kind of Busine	ss/Industry
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) 7th	College (1-4or 5+)	Housewi	1_		Home	
Maryland	Mental Mental arked c	To Be C	17. Father's Name (First, Middle, Last Raymond Gibson)				e (First, Middle La Dorses	, Maiden Surname)	
Mar	d 2 sho Ith and Ith and Ith is ma		19a. Informant's Name/Relationship (Paul M. Prather		- 1	Mailing Address (Street 59 Tobacco			-	
ď	ss 1 and 2 of Health item 27 i		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		Disposition (Name of , crematory or other place		Date	20c. Location - City	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	fy)		Grove Cem	11/2		Gaithers	J.
Ba	Departimon Important Impor	1	21. Signature of Funeral Service Lice	nsee	0				NERAL HOME kville, M	
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P.O. Box	The law requires that the death cer ate has been signed by the attendin age 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	ey		23d. Date of Month	Day Year
	w requires tha s been signed should be det	کر اکر	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause giv	en in Part I.		10	e to the cause of death? Probably 4 Unknown
of Vital Records,		Completed						24a. Was auto perfo	ormed? death	eutopsy findings available to completion of cause of ??
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		nationt 3 DOA Oth	26. Place of Deat	h (Check only	one)	
J of		n: To	1 Yes 2 No 27. Manner of Deeth	28a. Date of Injury (Month, Day,	28b. Ti	ime of 28c. Injur	ry at		idence 6 Other (S	pecify)
Division	Attending r death. sctor: After by the funer	catio	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n			Yes 2 □No			
Divi	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Certification: To	4 Homicide determined	building, etc.	(Specify)	m, street, factory, office		City or To	(Street and Number or wn, State)	
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 ★ Certifying Pl (Check only one) 2 ★ Medical Exam	minar: On the bacic of	avamination and	death occurred at the ti d/or investigation, in my o	aninian doath accur	wad at the time.	data and place and	due to the course(s)
	withii To the Comp	Ň	29b. Signature and title opertifier	i		29c. Licens	e number	Q.	29d. Date signed (Mo	onth, Day, Year) 24 20 0 9 20874
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (*	Type, Print) S Drive	Gen	mante	an mo	20834
	Sta Registr		31. Date filed (Month, Day, Year) OCT 29 20	109 Sekwa	's Signature	pares				
			<u> </u>	V						

	Physici		Decedent's Name (First, Middle, La.	,	20a-1	PCertif	icate of L	Jeath	2. Date of De Month			3 3 6 3 8 9 3. Time of Death
4	/Medic Examir Funeral	er	Kenneth Ray Prui 4a. Facility Name (If not institution, giv Peninsula Recgion 5. Social Security Number 10. Social Security Number 11. Social Security Number 12. Social Security Number 13. Social Security Number	e street and number) Name (A) Name	(In yrs. las	ntcr it birthday) If	City, Town, or Under 1 Year onths Days	Location of De If Under 24 H Hours M	ath Out 1 Irs. 8. Date of Bi	4c.	County of Deat	h hplace (State or Foreign untry)
	Director t show	tor	220-18-9879 Usual Residence of Decedent 10a. State 10b. County Virginia Accoma		34 10c. City, Tangi	Town or Location	on		0/29/1	.923	Vir	ginia 10d. Inside City Limits 1 XYes 2 □ No
	th with the P 23a or 28a- ust be notif	ral Director	10e. Street and Number 4385 Long Bridge		rangr	1	0f. Zip Code 23440			10g. Cit	izen of What Co	untry?
036	urs after dea al", or items Examiner m	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Decedent of His s, specify Cubar res 2 X No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	0-	14. Race - Ame Black, White Specify: Whi	e, etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Irs Medical Eventuar must be notified at once.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. Decedent (Give kind life. DO N	s Usual Occupa of work done di IOT use retired)	ition uring most of v	vorking	Ì	ind of Business/	
yland 2	ould be filed I Mental Hyg narked other natic event, I	To Be C	17. Father's Name (First, Middle, Last) Vernon Pruitt					Maggie		e, Maiden	Surname)	
re, Mar	s 1 and 2 sh of Health and item 27 is n other traun		19a. Informant's Name/Relationship (Deborah Gay Prui 20a. Method of Disposition	tt/daughter	r	4385 Lo	,	ge Rd.	Tangier, Date	Va		
Baltimo	permit. Page Department of Important: If any injury or once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Liber	y)		atley Co	emetery	10/ s of Facility	25/2009 Home P.A		gier, Vi	rginia
1	Physician		23a. Part1. Enter the disease, or comphock, or heart failure. List only Immediate Cause (Final disease or condition	polications that caused to one ouse on each line	1	501	Snow H	ill Rd	. , Saisbu diac or respiratory a	ry,	Marylan	Approximate Interval Between Onset and Death
	/Medical Examiner	iner	Sequentially list conditions, if any, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a b. Due to (pr as a	confequer HVL	hemi	fail	url		11	EXAMINER	years
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. <u>Subde</u> Due to (or as a	consequer		ră forma	CERTIF	CHON NO ROVED		X. D.	years
O. Box	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at 1 9 Unknown	Fetal d	eath 3□Ed	opic pregnancy ner <i>(specify)</i>				23d. Date of del Month	ivery Day Year
Records, P.	w requires that the designed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death but	not resulti	ng in the underl	ying cause give	n in Part I.				the cause of death?
Vital Rec	The la ate has page 2	• Completed	25. Was case referred to medical		-			00 81 (5	1 □ Yes	psy ormed? 2 40	prior to death?	ntopsy findings available completion of cause of
0 > 0 > 0 Division of Vi	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	ation: To Be	examiner? 1 Yes 2	28a. Date of Injury Found Day,	Year) 28	3/Outpatient 3 Bb. Time of Injury Inknown	DOA Other	r: 4 🗆 Nursing	g Home 5 Res 28d. Describe Multi	idence how injur		cify)
∯ Divis	pital or Atte burs after de leral Directo filled in by th	Il Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc. Found: ysician: To the best of	Home			e date and pl	Bridge	Road	l, Tangi	4385 Long er IslandMD
7	To the Hos within 24 h To the Fun completely	Medical	(Check only 2 Medical Exan	niner: On the basis of e and manner state	examinatio ed.	n and/or investi	gation, in my op	number	ccurred at the time	, date and	d place, and due	to the cause(s)
•	BEN		30. Name and rodress of person who	completed cause of dea	ath (Item 2	3a) (Type, Print	Doos	9931		-	10/22/0	9
	Sta Registr		30. Name and oddress of person who compared to the state of the state	ann, M - 32. Registrar 009	2. /	E. M.C	100 E	E. Car	rull St.	Sa	lisbury	MD 21801

Physic /Medi Exami

Funeral Director

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	Phy /N Exa	/sid led am	cia lica	in al
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 34 hours after death	To the Funeral Director: After this certificate has been signed by the attending physician and	 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 	

Registrar 1. Decedent's Name (First, Middle, Le		C	ertificate of E	Death ————————————————————————————————————	Reg. I	4o. C 0 0 5	3. Time of	391	
Romeo Edward Qui	,					Oay Year	2:30	P M	
4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death	1	c. County of Death		Ţ	
Casey House	,		Rockvill			Montgome			
Social Security Number 6.		yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea		nplace (State o	r Foreig	
578-30-9303 Usual Residence of Decedent	1⊠M 2□F 82	Yrs.	Months Days	Hours Min.	Jan. 22,19		intry)		
10a. State 10b. County	100	c. City, Town or	Location				10d. Inside Cit	ty Limits	
Maryland Montgom	ery s	Silver S	Spring				1 ¥ Yes	2 🗌 No	
10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?		
13 Briggs Court			20906		Uni	ted State	s		
11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13	 Was Decedent of His If Yes, specify Cubar 	spanic Origin? (Sp n. Mexican, Puerto		14. Race - Amer Black, White	ican Indian,		
1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	unk.	1 □Yes 2 No	Specify:		Specify: Bla			
15. Decedent's E (Specify only highest gi		16a. De	cedent's Usual Occupa ve kind of work done di	tion	16b.	Kind of Business/I	ndustry		
Elementary/Secondary (0-12)	College (1-4or 5+)	Direc	e DO NOT use retired) ctor of the cact Compli	Office	of Fed	leral Hig	hway		
	5+	Contr				ninistrat	ion		
17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle, Maid	en Surname)			
William Edward Qu	ıick			Loretta	Berdelle	Scott			
19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ailing Address (Street a	nd Number or Ru	ral Route Number, Cit	y or Town, State, Z	ip Code)		
Cheryl Evelyn Pop		5023	Chapel Cr	ossing,	Douglasvil	le,Geore	ia 3013	5	
20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Domous! from 2: 1	Ub. Place of Dis	position (Name of rematory or other place aptist Chu	ı	Date 20c.	Location - City or T	own, State		
4 □ Donation 5 □ Other (Spec	efty)	Cemete	aptist Chu: ry 22. Name and Addres	10/3	1/2009 Wo	odville,V	irginia	a	
Dalasia Y	1 (Desser		7400 Georg					c.	
23a. Part 1. Enter the disease, or con	pulications that caused the					iigtoii, DC	Approximate	e	
shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.	dodin. Bo not	onto the mode of dying	g, saoir as caraiac	or respiratory arrest,		Interval Bet Onset and I	ween	
disease or condition resulting in death)	a. Septicemi								
	Due to (or as a co	nsequence of):							
Sequentially list conditions,	b								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence or):							
that initiated events resulting in death) Last	c Due to (or as a co	neoguana of):							
	240 15 (6) 45 4 60	nocquence ory.							
	d								
IF FEMALE:	23c. If yes, outcome of p	reanancy							
23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death	3 Ectopic pregnancy			23d. Date of deli	delivery Day Year		
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	e or death	5 Other (specify)				•		
Part II. Other significant conditions	contributing to death but ==	of racultina in the	underlying source at the	n in Port I	23a Did tabasa	o use contribute to	the cause of d	leath?	
	_	r resulting in the	andenying cause give	n III Fall I,					
Parkinson's Di	.60000				1 Tes	∠NO3Pñ	obably 4 🔀 l	NIKLIOW	
					24a. Was an autopsy	prior to o	topsy findings	availabl	
					performed 1 □Yes 2 X	? death?	2 🗆 No		
25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)				
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient	2 ER/Outpat	tient 3 DOA Othe		ome 5 Residence	6 K Other (Spec	cify) Hosp	ice	
27. Manner of Death	28a. Date of Injury (Month, Day, Ye	28b. Time	e of 28c. Injury		28d. Describe how in				
1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	on	/ Ingul		es 2 □No					
3 Suicide 6 Could not		At home, farm,	street, factory, office	13.50	28f. Location (Street	and Number or Ru	ıral Route Num	nber,	
A I Homicide determine	building, etc. (S	pecity)			City or Town, Si	are)			
4 Homicide determined	Ibusialan, To the heat of m	amination and/or	eath occurred at the tim r investigation, in my op	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s	5)	
29a. Certifier 1 🔀 Certifying F	aminer: On the basis of examiner stated.					Data diseased (March			
29a. Certifier 1 X Certifying F	aminer: On the basis of exa		29c. License	number	29d.	Date signed (Montl	n, Day, Year)		
29a. Certifier 1 X Certifying F (Check only one) 2 Medical Exa	aminer: On the basis of exa and manner stated	MD		number 3748		tober 28,			
29a. Certifier 1 🗷 Certifying F (Check only one) 2 Medical Exa	aminer: On the basis of exa and manner stated.	MD	D6.						
29a. Certifier (Check only one) 29b. Signature and title of certifier J. ILD U.G. 30. Name and address of person who	aminer: On the basis of examiner stated. Chouly completed cause of death	(Item 23a) (Typ	DG.	3748	0c1	tober 28,			
29a. Certifier (Check only one) 29b. Signature and title of certifier	aminer: On the basis of examiner stated. Choule completed cause of death ou 6001 Mune 2. Registrar's	(Item 23a) (Typ	△ 6. Mill Road,	3748	0c1	tober 28,			

Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36391 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Mary 2009 Margaret Russell 23 17:13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan 29 Months Days Hours 1959 Washignton DC Director 50 215 70 9408 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland is and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 Tyto MD P.G Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20748 6607 Beachwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces Black White etc. þ 1 Never Married 2 X Married ☐ Yes 2 👿 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ WSSC Water Company Lab Tech 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lewis Holland Nancy Constantino other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Page 1 and 2 st ment of Health a ant: If item 27 is Drive, Camp Springs, MD Robert M. Russell (Husband) 6607 Beechwood 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or oth Nov 2.2 009 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Address of FacilityLee Funeral Home, inc 6633 Cld 21. Signature of Funeral Service Lice Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e Immediate Cause (Final of Hysicials disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 XNo Month Pregnant at time of death 9 Unknown the 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No ပ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred M-Natural work? 1 ☐ Yes $5 \square$ Pending 2 🗌 No Accident Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical V Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Murse Practioners To the best dury knowledge, death commed at the time, date and place, and dile to the cause(s) and mariner as stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Wendell Pearson,

OCT 28 2009

31. Date filed (Month, Day, Year)

M.D.

egistrar's Signatu

7503 Surratts Road, Clinton,

MI:

20735

			For State Registrar AMEND#19bperFH,	State of Maryla	ınd / Depa Co <i>Cel</i>	artment of H r <i>tificate of L</i>	lealth and M D <i>eath</i>	lental Hyg R	iene _{eg. No.} 2009	36392
	Dharaini		Decedent's Name (First, Middle, Last)	11/ 1/ 05/12 1.1-				2. Date of Deat	h	3. Time of Death
Н	Physicia /Medic		Lawrence C.C		Shao			October	2 ^{Day} , 200 ⁸ gar	4:44 Рм
	Examin	er	4a. Facility Name (If not institution, give s 11152 Powder Horn			4b. City, Town, or Potomac	Location of Death		4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Rirt	hplace (State or Foreign untry)
	Director		089-32-0304 №	^{M 2□ F} 76	Yrs.	Months Days	Hours Min.	(Month, Day, 05/15/19	Chir	ia
	Dur &		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	f sho	jo	MD Montgomery	7 Po	tomac					1 — Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
1	23a c		11152 Powder Horn I	orive		20853			Jnited Stat	
36	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🛣No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Chi	e, etc.
21215-0036	2 nou		15. Decedent's Educ (Specify only highest grade	eation	16a. Dece	dent's Usual Occup	ation during most of worki	na	16b. Kind of Business/	•
21	nthin / ne. nan "r	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	d) -	1	Nuclear Reg	gulatory
7	Hygier Hygier Int, In	S	17. Father's Name (First, Middle, Last)	5+	Direct	tor of En	gineering 18. Mother's Name		Commission Maiden Surname)	
au	d be r ental ked oi ic eve	To Be	Z1 Shao				Ys Wu	, .		
Maryland	shoul and M s mar	F		pe. Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number	r, City or Town, State,	Zin 60025
Σ ;	and 2 ealth n 27 i		19a. Informant's Name/Relationship (Type: Jeannine Shao Coll	ins/Daughte	r 545 W	west 110t est 100th	n St, Apt.	75 New	York, NY	10025
altimore,	ges 1 If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crer	osition (Name of matory or other plac	ce)	Date	20c. Location - City or	Town, State
	urtmer urtmer ortant: njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service icense	N	ational	Cremator	ss of Facility JOS	ph Gawl	alls Church er's Sons	Inc.
Ba	Depa Impo any i		William R. D	rugh	5	130 Wisco	onsin Ave	. NW Was	hington, D	C 20016
		5 1.	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the do e cause on each line.	eath. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)		Minutes					
	/Medical Examiner		Tooling in down,	Due to (or as a cons Arterioscl		Heart Dis	sease			3 Years
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons						
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
60,	icate be executed physician and the burial-transit		resulting in death) cast	Due to (or as a cons	equence of):					
68760,	phys the	edical	d							
.O. Box	The Hospital of Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	sy .		23d. Date of de Month	livery Day Year
ς, σ.	res mat signed b	by Pl	Part II. Other significant conditions con	_	-		en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ord	w require been signal should b		Hemochromatosis,	Hypertension	ı, Diabe	tes		1 🗆 Y	es 2⊠No 3∏P	robably 4 Dnknown
ec	has be	Completed						24a. Was a autops	sy prior to	utopsy findings available completion of cause of
<u>a</u>	ilcian: The certificate h rector, page						-,-,	perfor 1 XYes	2 □ No 1 □ Ye:	s 2 XNo
\text{7}	siciar certifi irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2	□ EB/Outpatio	ot a 🗆 DOA Oth	26. Place of Deat		ne) ence 6 ☐ Other (Spe	- oife ()
o	g rnys er this eral dir	n:To	27. Manner of Death	28a. Date of Injury	28b. Time o				ow injury occurred	эспу)
io io	ending reath.	atio	1 Natural 5 Pending investigation	(Month, Day, Year) Injury Work? M 1 ☐ Yes 2 ☐ No						
Division of Vital Records,	or Attendate after death	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp		reet, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
The state of the control of the cont										
	withir Comp	Me	29b. Signature and title of certifier	Lef M.	D	29c. Licens	se number	5	29d. Date signed (Mon	th, Day, Year)
	10		30. Name and address of person who co	impleted cause of death (Item 23a) (Type,	Print)			, ,	
			Martin W. Graf MD			Road #203	Rockvill	e, MD 20	0850	
*	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 9 2009	2. Registrar's Si	gnature	Ked.				
	negisti	ul	OCT 29 2009	person	10. pg-100					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 17 per fn g897 11-17-09 vt
State of Maryland Department of Health and Mental Hygiene AMEND 11EM 18, per FH, C897, 11/17/09 WS

Certificate of Death

Reg. No. 2005 36393 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, SCHONFELD Month Year Kolman **Physician** Hyman 12:30 P.[™] 26. 2009 Oct. /Medical 4c. County of Death
Montgomery 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring 1131 University Blvd. West #1607 8. Date of Birth (Month, Day, Aug. 5, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 062-24-3859 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min Days Hours 1 M 2 □ F Brooklyn, NY Aug. 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Silver Spring 1 □Yes 2 XNo Md. Montgomery Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20902 1131 University Blvd., West 12. Was Decedent Ever in US. Armed Forces? AVIIIVS. 1 MYes 2 □ No WWII If Yes, Give Year or Dates: 1943 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify \$ 3 Widowed 4 Divorced 1943 Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dentistry Dentist nd 2 should be filed walth and Mental Hygier 27 is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) -Mitzer Mintzer Bessie Schonfeld Anschel Adolph ၉ 19b. Mailing Address (Street and Number or Fural Flouts Number Gity of Fows State Fing Cod Md 20902 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar Muriel Schonfeld / spouse Department of Health Important: If item 27 any injury or other troops. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Oct. 29, 2009 Triangle, Va. cemetery, crematory or other plac Quantico National XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fun Service I 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between months Death Interstitial Lung Disease, Severe Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Box 68760X Due to (or as a consequence of) burial-1 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. the à 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à swallowing disorder 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27, Manner of Death 28b. Time of 28c. Injury at ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After t 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 27, 2009 10+1 D33159 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8700 Georgia Ave., Silver Spring, Md 20910 Ruth Kevess-Cohen, Date filed (Month, Day, Year) MDRegistrar's Signatur 29 2009 Registrar

Please T

'ype or Print in Black Indelible Ink. Ensure A	II Copies A	re Legil	ole.	
State of Maryland / Department of Health and Maryland / Certificate of Death		ene 2 0	09	36394
	Date of Death Month	Dav	Year	3. Time of Death

Physicia /Medica Examine

1 _ State

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. To Bo

Division or Vital Records, P.O. Box 68760,

State Registrar

Hegistrar		timouto or E			g. NO.			
1. Decedent's Name (First, Middle, Last) NORMAN LAWSON SH	EPHERD			2. Date of Death Month OCTOBER		3. Time of Death 12:35 P ^M		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death			
3940 BEXLEY PLACE # 715	4 1 1 1 1 1 1 1	SUITLAND If Under 1 Year	If Under 24 Hrs.	D Det - 4 Dist	PRINCE GEORGE'S			
578–18–4395 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	e (In yrs. last birthday) 90	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1/23/191	Year)	ASHINGTON, DC		
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
MARYLAND PRINCE GEORGE'S 10e. Street and Number	SUITLAND	10f. Zip Code		10	g. Citizen of Wh	at Country?		
5 ≅ 3940 BEXLEY PLACE # 715		2074	6	IIn	ited Sta	ates		
11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race -	American Indian,		
1 ☐ Never Married 2 ☐ Married 1 🕱 Yes 2 ☐ N	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Hican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify 1 Yes Give 1 Yes 2 RN No Specify							
15. Decedent's Education		dent's Usual Occupa	ition	1	6b. Kind of Busi	ness/Industry		
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done d DO NOT use retired)	uring most of work	ing		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Elementary/Secondary (0-12) College (1-4or 5	· I	ouse_Stor	e Clerk	U.	S Gover	oment		
17. Father's Name (First, Middle, Last)				e (First, Middle, M	aiden Surname)			
Leroy Shepherd			Ida Hay	es				
19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street a	nd Number or Rur	ral Route Number,	City or Town, Si	tate, Zip Code)		
Barbara Lathan / Daughter						y1and 20748		
20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of matory or other place		Date 2	0c. Location - C	ity or Town, State		
4 □ Donation 5 □ Other (Specify)	Lincoln M		10/30	/2009 S	uitland	, Maryland		
21. Signature of Fune of Service License		2. Name and Addres						
						ryland 20747		
23a. Part1. Enter the disease, or cor plications that caused shock, or heart failure. List on o e cause on each life	ne.				SI,	Approximate Interval Between Onset and Death		
disease or condition resulting in death)	CLEROTIC CO	JKUNAKI AI	KIEKY DIS	EASE				
	a consequence of): AL HYPERTEN	ISTON						
Securitally list conditions b.	a consequence of):							
cause. Enter Underlying Cause (Disease or injury that initiated events c.								
resulting in death) Last C. Due to (or as	a consequence of):							
d								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as cause. The control of the contr								
23b. Was decedent pregnant 23c. If yes, outcome 1 □Live birth	pf pregnancy 2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date			
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t time of death 5	Other (specify)			Mont	h Day Year		
in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contributing to death be STROKE CHRONIC OBSTRUCTIVE PULMON CHRONIC KIDNEY DISEASE 25. Was case referred to medical examiner?	out not resulting in the un	nderlying cause give	n in Part I	23e Did tob	acco use contrib	oute to the cause of death?		
STROKE	at not resolving in the un	naonymy oause give	ar ar r sare t.			Probably 4 Munknown		
CHRONIC OBSTRUCTIVE PULMON	NADV DTCEAC							
E	NAKI DISEAS)E		24a. Was an autopsy perform	/ pri	ere autopsy findings available for to completion of cause of eath?		
CHRONIC KIDNEY DISEASE				1□ Yes 2	K No 1 [☐Yes 2☐ No		
25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatie		ot 3 DOA Othe	· ·	h (Check only one				
	ury 28b. Time of	IL SELECT	4 Nursing no	ome 5X Resider 28d. Describe hove				
1 X Natural 5 □ Pending (Month, Ďa 2 □ Accident investigation	ny Year) Injury	Work	? ⁄es 2 ☐ No					
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injuding, etc.	ury - At home, farm, str	eet, factory, office		28f. Location (Str.	eet and Number	or Rural Route Number,		
building, et	c."(Specify)			City or Town,	, State)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 27. Manner of Death 28a. Date of Inju (Month, Da) 28a. Date of Inju (Month, Da) 28b. Place of inju building, et	of examination and/or in	h occurred at the tim vestigation, in my o	ne, date and place, pinion, death occur	, and due to the ca rred at the time, da	use(s) and man ate and place, ar	ner as stated. nd due to the cause(s)		
29b. Signature and title of certifler	. 0	29c. License #3325		29	d. Date signed	(Month, Day, Year)		
30 Name and address of person who completed gaves of d	leath (Item 22s) (Time	Print)		0	LV	, 2001		
30. Name and address of person who completed cause of d KAREN ANN BLACKSTONE, M.D.,			REET NW,	WASHING	TON,DC	20422/688		
31. Date filed (Month, Day, Year) OCT 2 9 2009 Annu 32. Registr	. parts							

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

	•	1 - State Amend Item 8	State of M	aryland g 906, 0	8/04/ Cer	rtment of F 2010dhb tificate of	iealth a Death	and Me	ntal Hy	giene 2	2009	3639
ō		1. Decedent's Name (First, Middle, Las							. Date of De Month	ath	Year	3. Time of Death
Physicia /Medic		Clemon Sturgis	3						10	25 25	2009	1748 M
Examin		4a. Facility Name (If not institution, give)		4b. City, Town, o	r Location o	of Death		4c. Co	ounty of Deat	h
		Poninsula Rogi	and I Ma	edica	1 Cer	Ha	26		XIV (11/1	COM	1100
Funeral		5. Social Security Number 6.1 Se	ex DXM 2□F 7.A0	ge (In yrs. la <i>I</i> I	(st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	. Date of Bir (Month, Da 10/18/	y Year) 1 935	Co	hplace <i>(State or Foreigr</i> untry)
Director		222-22-2721 Usual Residence of Decedent		4					10/10/	1733	VA	
yland Jow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
a-fsl	Director	DE Sussex	(Selk	yvil.	le						1 ☐ Yes 2 🔯 No
or 28	E	10e. Street and Number				10f. Zip Code				10g. Citizer	n of What Co	untry?
ath w	<u>a</u>	36362 Zion Chu				19975				U.S.		
er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	i. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Or an, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No can, etc.)	- 14.	. Race - Ame Black, White	
rs aft	by F	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2X1 If Yes, Give Year or Dates:	NO	1	□Yes 2 🛣 No	Specify:			D.S.	pecify:	
hou atura		15. Decedent's Ed	ucation	1	16a. Dece	ent's Usual Occup	ation				ack of Business/	Industry
hin 7% e. an "n: Medi	ple	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	(Give life. L	kind of work done OO NOT use retired	during mos d)	t of working				
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be filled within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, it a Modical Examinar must be notified at	Be (17. Father's Name (First, Middle, Last)				_	18. Mothe	er's Name (i	First, Middle	, Maiden Su	ırname)	
ould I Men arke	မ	Fred Sturgis							ırlin			
12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (7				g Address (Street						
ges 1 and 2 should be filed within 72 hours after death with the Manylan to f Health and Mental Hygiene. It if them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinal must be notified at		Mary Sturgis/Va	life	20h Pla	3636.	2 Zion (Chur	ch Ro		lbyvi 20c. Loca	11e,	DE 19975 Town, State
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"; or any injury or other traumatic event, it a Modical Examionce.		1 □ Vourial 2 □ Cremation 3 □		'		sition (Name of natory or other place	i				•	
artme artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify 21, Signature of Funeral Service Licen		Zoa		emetery . Name and Addre						lle, DE
permi Depa Impo any it		Signature of fullerar service Licent	- took		Be	ennie Si	mith	91			ella 9 MD 218	
		23a. Part 1. Enter the disease, or comp	olications that cause	d the death.			Home ng, such as				1D 21	Approximate Interval Between
Physician		shock, or heart failure. List only immediate Cause (Final	one cause on each 1		Stan	5,043	11 (Ge11	Lu	nac	ANCE	
/Medical		disease or condition resulting in death)	Due to (or as		ence of):	5,000	11.					
Examiner		Sequentially list conditions,	b									
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xecute and I-trans	хаш	that initiated events resulting in death) Last	c Due to (or as	a consequi	ence of):							
cate be executed by sician and the burial-transit			Due to (or ac	o a consequ	crice oi).							
ficate phys s the	dical		, d									
eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							230	d. Date of de	livery
death e atte d for	icia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant] Ectopic pregnand] Other <i>(specify)</i> _	СУ				Month	Day Year
t the by the	hys	9 Unknown	9 ☐ Unknown						1			
ss tha gned	y P	Part II. Other significant conditions of	ontributing to death I	but not resul	Iting in the ur	nderlying cause giv	en in Part I	l.	23e. Did	tobacco use	e contribute to	the cause of death?
en sig	ed	Pulmonary	Emple	1150	n				1 🗷	Yes 2	No 3 □ P	robably 4 Unknown
law re as be 2 shr	Completed by	HEPATIC	Insuff	1618	ncu	4			24a. Was		24b. Were au	utopsy findings available completion of cause of
The cate h	E O	Metabolic	Acid	1051	5				perfo 1 □ Yes	ormed? 2 No	death? 1 □ Yes	
cian: ertific	Be (25. Was case referred to medical examiner?				1		e of Death (Check only			
hysia this c	ဍ	1 Ves 2 No	Hospital: 1 Inpat		R/Outpatier	I 3 DOA					Other (Spe	ecify)
ling F After funera	ion	27. Manner of Death 1. ■ Natural 5 Pending	28a. Date of Inj (Month, D	ay, Year)	28b. Time of Injury	Wor			ld. Describe	how injury o	occurred	
ttend death stor: v the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	. —	niury - At hor	me form etr	eet, factory, office	Yes 2		of Location	Stroot and I	Number or P	ural Route Number,
lor A after Direc	Certification:	4 ☐ Homicide determined	building, e	tc. (Specify)	set, lactory, office				wn, State)	rvannber or m	urar rioute rvumber,
spita nours nerat			ysician: To the bes									
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending tompletely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medical Exan	niner: On the basis and manner s		ion and/or in	vestigation, in my	opinion, de	ath occurred	d at the time	, date and p	lace, and due	e to the cause(s)
To the To the Complex	Ž	29b. Signature and title of certifier				29c. Licens				29d. Date	signed (Mon	th, Day, Year)
m		J. JAJ				02	928	33		16	127	12009
, ,) ch	-	30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	+ 5	Solist	DUM	mp =	2180	
Sta Registr		31. Date filed (Month Pay Year) 8	2009 32. Regist	trar's Signat	ure	barker		1,	, , ,			П
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 For State Registrar 36396 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** 27 2009 1:42 10 Deborah Jean Shipley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury 422 South Boulevard Wicomico Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Hours Months Days 1 □ M 2 🛛 F Director 4-2-1949 Georgia 214-52-2356 60 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Experiment reast by nutfilled at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 1 ☑ Yes 2 ☐ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 USA Funeral 422 South Boulevard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ¥ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Cody Pierce Frances Virginia Sorrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Sue Shipley - Daughter 422 South Blvd., Salisbury, Maryland 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-30-2009 Salisbury, Maryland Parsons Cemetery 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Bounds Funeral Home las 705 E. Main Street, Salisbury, Maryland 21804 Who Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final Valvar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. E.it. of Deeping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 DaNo Month Day 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 □Yes : After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Nath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier uddleto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milford St. Suite 103, Salisbury, MD 21804 ton 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 28 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. O.

			- Megicular	Certificate of L	Death	Re	eg. No.	
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Joo	3. Time of Death p
	/Medic		Marian M. Smack 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	Current o	4c. County of De	
	Examin	er	Peninsula Regional Medical Cente	r Salis	bury		Wicon	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 18,	Year) 9. B 1937 Ma	sirthplace (State or Foreign Country) aryland
	w w		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	Maryta f sho	힏		sbury				1 ⊠Yes 2 □ No
	r 28a	irec	10e. Street and Number	10f. Zip Code		10	0g. Citizen of What 0	Country?
	th with	ralD	1700 Eastgate Drive	2180			U.S.A.	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be incitified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ※ Nover State of State	13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 No	ispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, iite, etc. white
0500-c	2 hour		15 Decedent's Education 16a.	Decedent's Usual Occup	ation	ng l	16b. Kind of Busines	
7	ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most or worki	ng	Restau	rant
7	led wi Hygier her th	S	10 17. Father's Name (First, Middle, Last)	Waitress	18. Mother's Name	(First, Middle, N		Lanc
yland	d be fi ental h (ed ol c evel	o Be	George Maurice Marshall			Anna Eva	*	
2	shoul ind Mi	오		Mailing Address (Street				e, Zip Code)
, Mai	and 2 ealth a s 27 is er tra		\"- '	2 A East Ma	in Street		Land, MD	21826
9	es 1 a of He if item		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of cemetery	Disposition (Name of y, crematory or other place	e) [20c. Location - City	
saitimore,	t. Pag tment tant: I		4 □ Donation 5 □ Other (Specify) Powe11:	ville Cemete		-2009 P	owellvill	e, Maryland
Da Da	permii Depar Impor any ir once.		21. Signature of Funeral Service Licensee Concur Short Vewell		neral Homove Stree			9940
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.			or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Su eve Aw Due to (or as a consequence of the condition of the conditions)	ite Pancree	hhi			
-	Examiner		Due to (or as a consequence o	1): E failure				
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of					
Ď,	rificate be executed ng physician and as the burial-transit	回旧	resulting in death) Last Due to (or as a consequence of	n).				
68/6U,	ficate p phys s the	edical	d					
O. BOX	To the Hospital or Attending Physician: The law requires that the death certifult 24 hours after death. within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	ey		23d. Date of Month	delivery Day Year	
ras, P.	quires that n signed by ald be deta	호	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	en in Part I.		bacco use contribute es 2 ☐ No 3 ☐	e to the cause of death? Probably 4 Unknown
I Records,	The law recate has bee page 2 shor	Completed				24a. Was a autops perform	sy prior	
VITAI	ician: sertific setor,	Be (25. Was case referred to medical examiner?	Oth	26. Place of Deat	h (Check only on	ne)	
0	Physi this c	은	1 Yes 2 To Hospital: Inpatient 2 ER/Out 27. Manner of Death 28a. Date of Injury 28b. T	tpatient 3 DOA Oth	4 LI Nursing Ho		ence 6 Other (5	Specify)
5	ding th. After	tion	1. Natural 5 ☐ Pending (Month, Day, Year) In 2 ☐ Accident investigation	njury Wor	k? Yes 2□No	200. 2000	,,	
DIVISION	al or Atter s after dea I Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office		28f. Locetion (Si City or Town		Rural Route Number,
	e Hospitt 24 hours e Funera letely fille	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the ti d/or investigation, in my o	ime, date and place opinion, death occur	, and due to the or red at the time, d	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To th withir comp	Me	29b. Signature and title of certifier	29c. Licens	se number	2	29d. Date signed (Mo	onth, Day, Year)
	0		- Stora May	D6	8222		10/26/0	9
	5 m		30. Name and address of person who completed cause of death (Item 23a) ((Type, Print) (St. St. St. St. St. St. St. St. St. St.	1/6/	· ma	2150	,
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4 21. 21	TUSOURG	y ma.	2100	/
	Registr		OCT 28 2009 Senera B.	paren				

Copies Are Legible.

09-00004	Please Type or Print in Black Indelible Ink. Ensure All
Steven Vance Standish	State of Maryland / Department of Health and Mer

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		1- For State Registrar	tate of Ivial yland	-	ificate of l		id Wichte		2 U U 1	9 3639
Physicia Medical Exami	an/	1. Decedent's Name (First, Midd Steven Vance	. ,					2. Date of Dea Month November	th	3. Time of Death 0034 hrs
redical Exami	1161	4a. Facility Name (if not instituti			4b	. City, Town, c	or Location of		4c. County of Deal	
		St. Mary's Hospital E				Leonardto			St. Mary's	
Funeral Director		5. Social Security Number 217-04-0008 Usual Residence of Decedent	6. Sex 7. Age	e (In yrs. las	t birthday) Yrs.	Months Da				rthplace (State or gnMaryland ountry)
, any		10a. State 10b. County		10c. City, T	own or Location	1				10d. Inside City Limits
Maryland 28a-f show d at once.	ţō		St. Mary's				at Mil			1 Yes 2 X No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f sho ratic event, the Medical Examiner must be notified at once.	Dire	10e. Street and Number 45895 Fox Cha				10f. Zip Code 206			0g. Citizen of What Cou US	A
or death wi	Funeral			Ever in U.S.	If Yes	, specify Cuba	n, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	White, etc.	rican Indian, Black, White
ours afte	d by	Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grade com	pleted) 1	16a. Decedent's		ation (Give kir		Specify: 16b. Kind of Business	
21215-0036 oold be filed within 72 ho d Mental Hygiene s marked other than "na tite event, the Medical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	•	t of working lif Special		se retired)	Compu	ters
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name (First, Middle					18.Mother's	Name (First, Middle, N	· · · · · ·	
212. uld be Mental marke	To Be	Earnest V. St			19b. Mailing A	ddress (Stre	et and Numbe		C. Evans	e, Zip Code)
MD d 2 sho lth and n 27 is		Earnest V. Standí	sh, Jr. / Fathe	-		Cat Creek			11e, MD 20659	
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th		20a. Method of Disposition 1 Burial 2 X Crematio 4 Donation 5 Other S	n 3 Removal from Sta	ite cre	on (Name of co rplace) Cremator	1	Date November 5, 2009	20c. Location - City o		
Balti permit. Departn Imports injury o		21. Signature of Funeral Service	Licensee		Ma P .		7-Gardin 270 Leo	er Funeral Ho nardtown, MD		
Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause	e on each line.						est, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse			vascul	ar dis	ease		Death
	_	Sequentially list conditions,	b							
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8760, ificate be g physicist the burn		IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outcom		incy	death 3	F 1		23d. Date of deliver	y Day Year
Box 687 death certific	sician/	past 12 months? 1 Yes 2 No 9 Un	4 Pregnant at	time of deat	h =	(Specify)	Eddplo p		I Worker	boy rour
O. B. It the de by the ached f	된	Part II. Other significant condi	9 Onknown	but not resi	ulting in the und	lerlying cause	given in Part	I. 23e. Did to	bacco use contribute to	the cause of death?
ires that the signed by d be detached	g b	Diabetes mel	litus					1Yes	2 No 3 Pro	babiy 4 🗸 Unknown
cords, aw requir	Completed			_				24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
Vital Recol		05 M(00 5		1 🗸 Yes		es 2 No
Vital ysician: his certifi director.	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Heavital:	nt 2 🗸 E	R/Outpatient :		Other	heck only one)	Residence 6 Othe	er:
Division of Vital Records, rate death. s after death. al Director: After this certificate has been sed in by the funeral director. page 2 should I	-	27. Manner of Death	28a. Date of Injui (Month, Day,Ye	y 2 ear)	8b. Time of Inju		ury at Work?		now injury occurred	
Sior Attend r death. ector: by the	catic	2 Accident Inve	stigation 280 Place of Ini	ury - At hom	ne farm street		Yes 2 N		Street and Number of D	ural Route Number, City
Divi	Certification:		Id not be semined (Specify)	ury - At Holi	ie, iaiiii, street,	lactory, office	bulluling, etc.	or Town, S		urai Roule Number, City
The first of the f										
F 3 F 3	ŝ	29b. Signature and title of certific				29c. Licen			29d. Date signed (Mo	
	- [uness		-11. (**	0>	O.C	.M.E.		November 4, 20	09
		 Name and address of persor Ana Rubio MD. Ass 	who completed cause of desistant Medical Exam		^{3a)} 1 <mark>1 Penn St</mark> r	eet, Baltim	ore, MD 2	1201		
St: Regist		31. Date filed (Month, Day, Year)	22. Registrar	's Signature	park	p				
Kegist	LL L	1404 - 0 4	UUS CENEVA	- Jan	7					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician NANNIE OCT. 7:35AM M Α. TINSLEY 26 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. THOMAS MORE HYATTSVILLE P.G. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 230 03 8241 1 □ M 2 🔀 F DEC Director 92 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 TYes 2 □ No MD. P.G. RIVERDALE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5611 SIGNET LANE 20737 Funeral USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2X No Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event. In Mental Informatic event. Elementary/Secondary (0-12) College (1-4or 5+) NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS ALEXANDER CLARICE DAY ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VINCELL MCALLISTER/DAUGHTER 5611 SIGNET LANE RIVERDALE MD. 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State FOREST HILLS 10/31/09 LYNCHBURG, VA. 4 □ Donation 5 □ Other (Specify) 20010 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility WATSON F H 3435 14th ST., N.W. WASH. DC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus a or wach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 1 □Yes 2 XNo 9 Unknown 9 ☐ Unknowh 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑No 24a. Was an page 2 s autopsy performed? Yes 2 700 certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Voluming Home 5 Residence 6 Other (Specify) Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)006368 10 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AJIT KURUP 4922 LASALLE ROAD HYATTSVILLE, MD. 20782 State OCT 2 9 2009 Registrar

09-08545 Robert Warren Tucker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 36400

		1- For State Certification 1. Separt 1. For State Certification 1. For Stat	ificate of Death		200) Reg. No.	3 3040
Physici dical Exam		Decedent's Name (First, Middle,Last)		2. Date of Dea Month Novembe	ath	3. Time of Death 1916 hrs
		4a. Facility Name (if not institution, give street and number) Civista Medical Center	4b. City, Town, or Location LaPlata		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		er 24Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bir	thplace (State or
Director		219-72-6342 1XM 2F 49	Yrs. Months Days Hours		5, 1960 Wa	_n Shington DC
* any		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	tor	MD Charles Col	bb Island			1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	16069 Hawks Nest Place	10f. Zip Code 20625		10g. Citizen of What Cou USA	ntry?
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		gin? (Specify Yes or No		can Indian, Black,
fter dea l", or it		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	•		hite
hours a natura	ed by		6a. Decedent's Usual Occupation (Give during most of working life. DO NOT	kind of work done	16b. Kind of Business/I	
136 thin 72 ne. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Contractor	ase reares,	Construct	ion
21215-0036 uold be filed within 72 hours a Mental Hygiene. marked other than "natura c event, the Medical Examin		17. Father's Name (First, Middle, Last) Robert Warren Tucker		r's Name (First, Middle, ith Myers		
7. 2 2 2 3 1	То Ве	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Nun	mber or Rural Route Nur		, Zip Code)
re, MD s I and 2 sh of Health and If item 27 is		Judith Ruth/Mother 20a. Method of Disposition 20b. Pla	ne, La Plat		Taura Chata	
imore, MD 2 Pages I and 2 shoul ment of Health and M tant: If item 27 is no or other traumatic		1 X Burial 2 Cremation 3 Removal from State Code	are of Disposition (Name of cemetery, ematory or other place) ar Hill Cemetery	Date 11/9/09	20c. Location - City or Suitland,	
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee M01458	I an		1	maryland
		23a. Part I. Enter the disease, or complications that caused the death. De	211 St. Mary	's Ave. La	Plata, MD 2	0646
Physician /Medical		failure. List only one cause on each line.	phine) intoxication			Approximate Interval Between Onset and Death
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	iner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause				
ted I Insit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	ledical	X UNPENDED AMENDED 23a, 27, 28a	n-f,permE, g897 11/	/13/09 TT		
8760, tificate be ng physic as the bur	≥	23b. Was decedent pregnant in the	nicy	c pregnancy	23d. Date of delivery) Day Year
Box 687. he death certific y the attending p	hysician	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown			, worth	voj redi
P.O. B that the d ned by the detached	_ □		ulting in the underlying cause given in Pa	art I. 23e. Did to	obacco use contribute to	the cause of death?
ords, P.C. w requires that as been signed I should be deta	ted by			_	s 2 No 3 Prob	
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Vital Recysician: The his certificate director, page	Be Co	25. Was case referred to medical	26.Place of Death	(Check only one)	2 No 1 Ye	s 2 No
Physici rathis o	To B	1 7 165 2 140	R/Outpatient 3 DOA Other	Nursing Home 5	Residence 6 🗸 Other	: Scene
C = 2 - 2 - 2	tion:	1 Natural 5 Pending 11/3/00	Bb. Time of Injury 28c. Injury at Work D 7:00 pm		how injury occurred	
Division Spital or Attendii hours after death. neral Director: A	ertificati	3 Suicide 6 X Could not be 28e. Place of Injury - At home	e, farm, street, factory, office building, et		Street and Number or Rui	ral Route Number, City
.g. ⊜ .g.	9	4 Homicide determined (Specify) reside 29a. Certifier 1 Certifying Physician: To the best of my knowledge,		PI ISS	ue, MD	
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner: On the basis of examination and/	or investigation, in my opinion, death oc		and place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mor	
	ł	30. Name and address of person who completed cause of death (Item 23	3a)			
	ate	Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature		e, MD 21201		
Regist		NUV U 6 2009 Areus A. A	parker			

			Please Type or Print in					_		
		1	For State of Maryla		artment of He rtificate of D			eg. No. 2009	36401	
Ph	nysicia	ın	1. Decedent's Name (First, Middle, Last) Paula F. Weinstock				2. Date of Dea Month	th Day Year	3. Time of Death 9257 AM	
	Medic kamin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L		apper	4c. County of Death		
			Shady Grove Adventist Hospita 5. Social Security Number 6. Sex 7. Age (In y.	rs. last birthday)	Rocks		8. Date of Birth	Montgon 9. Bi	rthplace (State or Foreign	
	neral ector		216-40-5227 1 □ M 2 N F 67 Usual Residence of Decedent		Months Days	Hours Min.	8. Date of Birth (Month, Day June 15	,1942 of	^{ountry)} District Columbia	
ryland	H			City, Town or Lo					10d. Inside City Limits	
the Ma	outfle	recto	MD Montgomery 10e. Street and Number	G	aithersbur	rg		l0g. Citizen of What C	1 ☐ Yes 2 🛣 No ountry?	
ath with	ust be	Funeral Director	425 N. Frederick Avenue		2087	<u> </u>		United		
5-UU36 72 hours after death with the Maryland hatural", or items 23a or 28a-f show	of other than "natural"; or tems 23a or 28a4 show event, the Medical Experiment must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 💢 No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or N <i>o-</i> Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.	
IZIS-0036 ithin 72 hours aff ne. han "natural".or	Sical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)		ng	16b. Kind of Business	/Industry	
C Z1Z1 filed within Hyglene.	the Ms	omo	Elementary/Secondary (0-12) College (1-4or 5+)		Hard Line	Goods				
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Baltimore, Maryland Z permit. Pages 1 and 2 should be filed bepartment of Health and Mental Hygi important: If fiem 27 is marked other	traumatic	To	19a. Informant's Name/Relationship (Type. Print) Miriam Weinstock/ Daughter			nd Number or Rura	al Route Numbe	r, City or Town, State, hersburg,		
Saltimore, bermit. Pages 1 an Department of Heal	or other	ŀ	20a. Method of Disposition 20th	p. Place of Dispo cemetery, cren	sition (Name of matory or other place)	; .	er 23	20c. Location - City of	r Town, State	
AITIM mit. Pa partmer	injury e.		4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee	etropoli Crema	Leary 2. Name and Address			Alexandria		
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bU, be executed ician and	for use as the burial-transit	Ш	that initiated events c. C. Due to (or as a cons	equence of):						
certificate	as the t	ledica	d							
O. BOX he death cer the attendir	thed for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year	
ecords, P.O. law requires that the as been signed by th	uld be detac		Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause given	in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown	
ate h	page 2 sho	Completed by	closhiduin dificille to	an coli	tis		24a. Was a autops perfor	sy prior to med? death?	autopsy findings available completion of cause of s 2 \(\sum \) No	
VITAL sician: T	irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: ☐ Inpatient 2	□ EB/Outpatier	Othor	26. Place of Death	,	ne) ence 6 ∐Other <i>(Sp</i>	onife)	
n OT Ing Phy After this	neral d	on: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year,	28b. Time of	f 28c. Injury : Work?	at		ow injury occurred	еспуу	
JIVISION OT VITA or Attending Physician: after death. Director: After this certific	in by the fu	Certification:	Accident 3 Suicide 4 Homicide investigation 28e. Place of Injury - Albuilding, etc. (Spe	home, farm, streecify)		es 2 No	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,	
To the Hospital	stely filled	edical Co	29a. Certifier (Check only one) (Check only one) (Check only one)	nowledge, death	h occurred at the time vestigation, in my opi	e, date and place, inion, death occurr	and due to the ored at the time, or	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)	
To the vithin	compl	Mec	29b. Signature and title of certifier	MA	29c. License	number 453	2	29d. Date signed (Mor	oth, Day, Year) 21 2008	
- /			30. Name and address of person who completed cause of death (I		Print) HADY 61	Park D	o Pag	Dung	40 2000	
	Stat		31. Date filed (Month, Day, Year) 32 Registrar's Sig		10107 07	COVE IC	y roc	KVICER 1	10 -0000	
Re	egistra	ir	OCT 29 2009 Setus	B. 196	N. Co.					

State of Maryland / Department of Health and Mental Hygiene 36402 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 5:20 pm October 26. 2009 John Alva Watkins, III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Montgomery General Hospital Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/14/1963 **Funeral** Hours Days 1 🕅 M 2 🗆 F Months 219-82-0856 46 Director washington. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Exemples regat be notified at 1 ☐Yes 2 🕅 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14220 Alderton Road permit. Pages 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the "Noticel Expriner", ast once. by Funeral 20906 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. White. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber 12 JCM Associates. Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Alva Watkins, Jr. ဂ္ Peggy J. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Imelda Watkins - Wife 14220 Alderton Rd., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Gardens 10/30/2009 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licer see 11800 New Hampshire Ave., Silver Spring, MD 20904 23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** encephalopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as the burial-transit Diabetes melletus and Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Munpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier t certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna K. Paspula, M.D., 18404 Oxfordshire Terrace, Olney, MD 20832 31. Date filed (Month, Day, Year) OCT 29 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36403 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2:09 р.м MARJORIE C. WILLIAMS 21 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 505 SUFFOLK AVE. # 316 CAPITOL HEIGHTS PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Washington, DC **Funeral** Days 1 M 2 XF Months Hours Min Month, Day, Y 30/193 Director 577-50-6526 Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MARYLAND PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 505 SUFFOLK AVE. 20743 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: BLACK 3 Wildowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygier 7 is marked other t DOCUEMENTS EXAMINER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any Injury or other traumatic. JAMES MADISON other traumatic CARRIE MARJORIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN A. WILLIAMS / SON 9315 DRAWBRIDGE RD. MECHANICSVILLE, VA 23116 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) RESURRECTION 10/28/2009 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. M00981 5538 MARLBORO PIKE FORESTVILLE, MARYLAND 20747 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 2003 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Physician/Medical Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown the detached Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIAbetes should be Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? certificate Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No ဂ္ 1. Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina after death.

Director: Aft
d in by the fun 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene.

	1	For State of Ma		tificate of Death	Reg	g. No. 2009	36404
Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Sandra Beatrice Wyvil	1		Oct 25,	2009 Year	11:33 P ^M
/Medic Examin	er	Aa. Facility Name (If not institution, give street and number) Anne Arundel Medical Ce		4b. City, Town, or Location of Deat Annapolis If Under 1 Year If Under 24 Hrs		4c. County of Deat Montgo	mery hplace (State or Foreign
Funeral Director		220 40 2903 1□M 2∏F	(In yrs. last birthday) 66	Months Days Hours Min.	8. Date of Birth (Month, Day, Dec 12,	Year) Co	yland
//aryland f show		Usual Residence of Decedent 10a. State 10b. County MD PG	10c. City, Town or Lo	er Marlboro			10d. Inside City Limits 1 □Yes 2 XXI
with the Na or 28a-	Funeral Director	10e. Street and Number 15109 Mt Calvert Road		10f. Zip Code 20772	10	United St	
within 72 hours after death with the Maryland sien. yiene. than "naturel", or items 23a or 28a-f show than "haturel" or items 21a bundlified at the Macheal Examiner must be multified at	by Funera	11. Marital Status 1 ↑ Never Married 2 ↑ Married Status 1 ↑ Never Married 2 ↑ Married Status 1 ↑ Never Married 2 ↑ Married Status 1 ↑ Yes, Give A ↑ Year or Dates:	lo	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 1 □Yes 2 ★ Specify:			e, etc. hite
d within 72 hours afi giene. er than "naturel", or , he "tedeal Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	+) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)		16b. Kind of Business	
	Be	12 17. Father's Name (First, Middle, Last) William Wyvill	Di	rector 18. Mother's Na	me (First, Middle, N	Maiden Surname)	
Z c z	2	19a. Informant's Name/Relationship (Type. Print) Maria Jackson (Sister)		ng Address (Street and Number or F Northhampton Dr	ive, LaPl	ata, MD 20	646
Hear there		20a. Method of Disposition 12 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Resurre	osition (Name of matory or other place) ection Cemetery 1	0/30/2009		Maryland
permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 23. Part 1. Enter the disease, or complications that cauch licensee and cauche and	Road, Cli		20735 Approximate Interval Between		
Physician /Medical Examiner		shock, or heart failure. List only one cause on the limmediate Cause (Final disease or condition	ic.	un Embolis			Onset and Death
ifficate be executed g physiclan end as the burial-transit	edical Examiner	cause (Disease or injury that initiated events	a consequence of): a consequence of):				
eath certifi attending for use as	Physician/Med		2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of o	Day Year
ires that the designed by the	5	Part II. Other significant conditions contributing to death the Atrial Fibr. (atra)	out not resulting in the	underlying cause given in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
In Attending Physician: The law requires the death. In or Attending Physician: The law requires the death. Intector: After this certificate has been signed in by the funeral director, page 2 should be on the funeral director.	Completed	Cardiomyopathy.			24a. Was autop	an 24b. Were prior to death 2 1 No 1 Y	
Physician: The Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	ient 2 ☐ ER/Outpati	Other:	Death (Check only o	dence 6 ☐ Other (S	pecify)
ding Physician: The In. After this certificate hat funeral director, page	tion: To	27. Mann r of Death 28a. Date of Inj (Month, D	ury 28b. Time	of 28c. Injury at	•	now injury occurred	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Ir building, €	njury - At home, farm, setc. (Specify)		City or Tov		
ne Hospital n 24 hours a ne Funeral l pietely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the bess and manner sand manne	of examination and/or	investigation, in my opinion, death c	lace, and due to the courred at the time,	date and place, and	
To the within 2 To the comple	Me	29b. Signature and title of cortifier		29c. License number	297	29d. Date signed (M.	
RAZA		30. Name and address of person who completed cause of	death (Item 23a) (Typ	e, Print) O Medical PK bank	ing Ani	napolis M	12009 D 21401
S Regis	tate strar	31. Date filed (Month, Day, Year) OCT 28 2009 22. Hegis	strar's Signature	back	7		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 36405 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month FRANCES ANN WEBB 2009 15:43 P /Medical 4a. Facility Name (It not institution, give street and number) PENINSULA REGIONAL Examiner 4b. City. Town, or Location of Death 4c. County of Death SALISBURY WICOMICO MEDICAL CENTER
5. Social Security Number 6. Sex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. JULY 8, 1941 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 221-26-3592 68 Director VIRGÍNIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c City Town or Location ral", or items 23a or 28a-f show Evarviner must be notified at 10d. Inside City Limits DELAWARE SUSSEX Director BRIDGEVILLE 1 □Yes 2 TNO 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11400 ABBYS WAY 19933 Funeral AMERICA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or <u>გ</u> 1 ☐ Yes 2 X No Specify SpecifyWHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMEMAKER 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NED TALLENT 2 MYRTLE SANFORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11400 ABBYS WAY BRIDGEVILLE, DE. 19933 FRANCIS W. WEBB HUSBAND 20b. Place of Disposition (Name of semester) Communication (Name of ST JOHNS TOWN NT CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ENTOMBMENT OCT.31,2009 GREENWOOD, DE. 21. Signature of Fuperal Se FRONT & KING STREETS SEAFORD, SEAFORD, DE. 21 Part 1. Enter the disease shock, or heart fallure. n ications that c used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (mal disease or condition resulting in death) Physician a AULTIC AND MITRAL VANS REPLACEMENT HOURS /Medical Due to (or as a consequence of): Examiner The AND MERRY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Yerres Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIM FIRELATIO 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 1 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)_ To the I within 2 29b. Signature and title of certifier 29c. License number OCTUBER 23 2009 ne and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Salisbury MD. 21801 P.R.M.C. II MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mic	ai yiai iu i	Cei	rtificate of	Death	R	eg. No 2	009	36406
		-11	Decedent's Name (First, Middle, Last)						2. Date of Deat Month		Year	3. Time of Death
	Physici /Medio		Jean	I.		Wa	11ace		October			3:15 P M
4	Examin		4a. Facility Name (If not institution, give st	reet and number)			4b. City, Town, or	Location of Death			nty of Death	
3			Wicomico Nursing H		<i></i>		Salisbu	ry If Under 24 Hrs.	l o Data of Diet		comico	(0)
b	Funeral Director		5. Social Security Number 213-12-5384 Usual Residence of Decedent	M 2 🗓 F	e (In yrs. last	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 2-2-192	Year)	9. Birthp Cour Dela	
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation				1	I0d. Inside City Limits
	Mary Ff sh	to	MD Wicomico		Sa	lisb	urv					1 X Yes 2 No
	or 28g	Funeral Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Cour	ntry?
	23a cust be	ral	702 Parkway Circle					1804			USA	
	ems	nei	11. Marital Status	Was Decedent B Armed Forces?		13.1	Was Decedent of H If Yes, specify Cuba	ispanic Ongin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show hipty or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:			1 ☐ Yes 2 💢 No					nite
5	"natı	lete	15. Decedent's Educ (Specify only highest grade	completed)		6a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work d)	king	16b. Kind of	f Business/In	dustry
12	withir ene. than he M	E C	Elementary/Secondary (0-12)	College (1-4or 5	+)		les Direc			Trar	Transportation	
7	filed Hygi other ent, tl	Be C	17. Father's Name (First, Middle, Last)			0.00	227	18. Mother's Nam	e (First, Middle, I			1011
lan B	lid be fental rked o	To B	Thomas		Iz	ydore	2	Lena		K	Coscins	ski
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ	e. Print)		19b. Mailir	ng Address (Street	and Number or Rui	ral Route Number	, City or Tov	vn, State, Zip	Code)
	and 2 ealth a n 27 is		Charlotte Patterso	n – Daugl	hter	702]	Parkway C	ircle, Sa				
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re	emoval from State	20b. Place	e of Dispo etery, crei	sition (Name of matory or other plac	ce)	Date	20c. Locatio	on - City or To	own, State
Ĕ	Pages iment of the tant: If the jury or or		4 □ Donation 5 □ Other (Specify)		Crema	tory	of Delma	arva 10 - 2				aware
Baltimore,	permit. Page Department Important: If any Injury or once.		21. Signature of Euneral Service License	Ly Blo	rbe-	70	2. Name and Addre	n Street,	ounds Fun Salisbu	ury, M		nd_21804
۲			23a. Part . Enter the disease, or complic shock, or heart failure. List only on	nons that caused cause on each lin	the death. [Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
20.1	Physician		Immediate Cause (Final disease or condition		Mes		a					Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as								
ь	Examine	_	Sequentially list conditions, b.	Due to (or as		100 of):						
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ice oi).						
	al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consequen	ice of):						
68760,	siciar buria											
189	tificate be executed ig physician and as the burial-transit	edical										
Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely illied in by the funeral director, page 2 should be detached for use.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	eath 3E	⊒Ectopic pregnancy ⊒ Other (s <i>pecify</i>)	,			Date of delive Month	ery Day Year
ص	that ined by detail		Part II. Other significant conditions conf	tributing to death bu	ut not resultin	ng in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use c	ontribute to t	he cause of death?
rds	quires n sign	d b	CONGEST/VE	HEAR	T	1A	LUNE		1 🗆 Y	es 2□No	o 3 ☐ Prot	bably Unknown
Reco	sician: The law re s certificate has bee irector, page 2 sho	Completed by							24a. Was a autops perfori	med?	prior to co death?	opsy findings available impletion of cause of
ta	an: T		25. Was case referred to medical					26. Place of Deat		a No	1 ☐ Yes	₽ No
<u> </u>	ysici is cer direct	To Be	examiner?	ospital: 1 🔲 Inpatie	nt 2 ER	/Outpatier	nt 3 DOA Oth	or:	ome 5 Reside		Other (Special	fy)
Division or	ng Phys ter this neral di		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju		Bb. Time o	f 28c. Injur Wor	y at k?	28d. Describe he	ow injury occ	curred	
<u>S</u>	endir. ath. or: Al	atic	2 ☐ Accident investigation					Yes 2□No				
Ž	ter de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injubulding, etc	ury - At home c. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location (St City or Town		mber or Rura	al Route Number,
	ospital of hours all uneral C		29a. Certifier 1 Certifying Phys	inter: To the best	of my knowla	dae dest	h occurred at the ti	me date and place	and due to the c	aueale) and	manner ac c	tated
	24 ho 24 ho Fun etely	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the basis of and manner sta	f examination	and/or in	vestigation, in my	ppinion, death occu	rred at the time, d	late and place	ce, and due t	o the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Me	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date sig	gned (Month,	Day, Year)
	△		Madail	411/			D 6	0515		10/2	6/09	
	4		30. Name and address of person who cor	npleted cause of de	eath (Item 23	Ba) (Type,	Print)	- , , , ,				
	Sil		Mahesha Thimmaraya				rn Shore	Dr., Sal	isbury,	MD 218	304	
	Sta Registi	-	31. Date filed (Month, Day, Year) OCT 28 20		ar's Signature		back					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 36407 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:30 AM Whiteman 2009 Mav Doris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany 701 East Fourth St. Apt. 403 Cumberland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 2, 1930 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1□ M 2□ F 215-26-6888 79 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show event, the Medical Examinar must be notified at 1 □Yes 2 □ No Cumberland MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 701 East Fourth Street Apt. 403 21502 USA 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ Specify: white 3 XWidowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Im. M. Once. McCroy's Restaurant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olivia (Alderton) Shambaugh Ovev Shambaugh 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12606 Katie Drive, SE Cumberland MD 19a. Informant's Name/Relationship (Type. Print) MD 21502 daughter Linda Davis 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/6/2009 Sunset Memorial Park MD Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or se a consciuone of): Approximate Interval Between Onset and Death Rew your **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 20 No 4 Nursing Home 5 Residence 6 □ Other (Specify) 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Peath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Secrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of

NTAVE.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

			1 - State of Ma	aryland / Depa <i>Cer</i>	artment of Heartificate of De		ental Hygi Re	ene g. No. 2009	36408
	Physici		Decedent's Name (First, Middle, Last)	COM.			2. Date of Death Month Novembe	Day Year	3. Time of Death 8:10 P M
	/Medio Examin		Gerald Enos Wolfin 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo Freder		Novembe	4c. County of Death	
	Funeral Director		Frederick Memorial Ho 5. Social Security Number 6. Sex 179-14-6318	SPITAL ge (In yrs. last birthday) 87 Yrs.	If Under 1 Year If	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/16/	9. Birth	place (State or Foreign intry) nsylvania
e, Maryland 21215	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be natified at once.	To Be Completed by Funeral Director	10b. County MD Frederick 10e. Street and Number 6441 Jefferson Pike, 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or Street) 17. Father's Name (First, Middle, Last) Enos F. Wolfinger 19a. Informant's Name/Relationship (Type. Print) Dennis Wolfinger / so 20a. Method of Disposition 1 Burial 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	No 13. No 14. No 15. No 15. No 15. No 15. No 15. No 15. No No No No No No No N	rick 10f. Zip Code 21703 Nas Decedent of Hispaf Yes, specify Cuban, It Yes 22 No 32 Ident's Usual Occupation in the Conference of Survey of Sur	anic Origin? (Spe Mexican, Puerto F Specify: on ing most of workin er B. Mother's Name Ida Ch d Number or Rura Wood I 11/7 of Facility Kee	(First, Middle, M. aittick Route Number, Ln, Fre ate 2 7/09	g. Citizen of What Cou United 14. Race - Amer Black, White, Specify: Wh: 6b. Kind of Business/li	States ican Indian, etc. ite industry 2 ip Code) D 21703 iown, State rg, MD
8760,	death certificate be executed e attending physician and d for use as the burial-transit	an/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as c	a consequence of): a consequence of): a consequence of):			r respiratory arre	23d. Date of deli	
l Records, P.O	The law requires that the date has been signed by the page 2 should be detached	Completed by Physician/M		at time of death 5	Other (specify)	in Part I.	1 ☐ Yes 24a. Was an autopsy perform	prior to c ed? death?	
on of Vital ling Physiclan; T	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification: To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	ury ay, Year) 28b. Time of Injury 28b. Time of	nt 3 DOA Other: 28c. Injury al Work? 1 Yeset, factory, office 29c. License n	tt 2 s 2 \(\text{No} \) , date and place, a inion, death occurre	ne 5 Resider 28d. Describe how 28f. Location (Str. City or Town, and due to the caed at the time, da	nce 6 Other (Special Indiana I	ral Route Number, stated. to the cause(s)
	Sta Registr		30. Name and address of person who completed cause of control of the state of the s	death (Item 23a) (Type, Fred 2 rar's Signature	Print)	2170	Z Dr.	Michael	Tolino

5 K DHMH 17 Rev 1/2001

Mr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 11:25 Iris M. Ashman November 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkville Oak Crest Care Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 17, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F 72 Maryland 1937 219-26-7738 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Modical Examiner must be notified at MD Baltimore Parkville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with U.S.A. 21234 8820 Walther Blvd. Apt. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Bartol Thomas Peters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8820 Walther Blvd. Apt. 1214, Parkville, MD 21234 Richard Ashman/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Date 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/09 Rosedale, MD Cemetery 22. Name 22. Nam. and Address of Facility Evans Funeral Chapel & Cremation Services 21. Signs ture of Funeral Service, Licensee 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest splock, or heart failure. List only one cause on each line. Immediate Cause (Final Yrs. **Physician** di Le or condition resulting in death) /Medical Due to (or as a or isequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day ₽ 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide LOVE PROCTITIONER 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

Box 68760, Ö Records, Division of Vital To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

Maryland 21215-0036

Baltimore,

ンサイエンサ

3

Registrar

29b. Signature and title of certifier

29c. License number R043580 29d Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8832

WATHER BLUD Batto MD

INC 31. Date filed (Month, Day;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day James Luther Alford 7:58p M 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Balto Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 2-7-1937 240-54-6419 Director 72 N.C Usual Residence of Decedent Show 10b. County 10a, State filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits or 28a-f 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 857 Lenton Avenue 21212 S Α 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Black, White, etc. 9 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Black "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MICA 12th grade Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve John Luther Alford Dollie Mae McCallum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie M. Alford-brother 418 Dunhill Dr Durham, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Baptist Ch 11-16-09 Cannon Suffolk, Va 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H la an Balto, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue MDApproximate Interval Between Onset and Death Immediate Cause (Final Enysician/ Astrocutorno disease or condition worth-Medical resulting in death) Due to (or as a consuluence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): sician and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death ed by the a Yes 2 No 9 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires Division of Vital Records, Undertrobule authorno botthe 3 Probably 4 Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or comment within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work' Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

08.09

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

rontown

29d. Date signed (Month, Day, Year)

2,3000

			Amend 28b per Mi	se Type of 8897 1 State	Print in 724/09 of Maryla	Black In nd / Depa	delible In	k . Ensur Health an	e All Copies d Mental Hy	s Are Le	gible.		
		1	For State Registrar			Cer	tificate of L	Death		Reg. No 2 0	09	36411	
	D I	,	Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death	
	Physiciai Medic		MARY ANNA BUTLER						<u></u>		009	2320 м	
100	Examin		4a. Facility Name (if not institution, GILCHRIST CENTER	3		to the total	4b. City, Town, o TOWSO				BALTIMORE 9. Birthplace (State or Foreign		
	Funeral Director		214-26-4700	6. Sex 1 ☐ M 2 🙀 F	7. Age (In yrs	last birthday) Yrs.	Months Days		Oct. 16	, 1926		ryland	
	show at	٥	Usual Residence of Decedent 10a. State 10b. County			City, Town or Loc						10d. Inside City Limits	
	Maryla 28a-f	rect	Maryland Baltin	nore	В	altimor	e County					1 Yes 2XXNo	
	h the	Funeral Director	10e. Street and Number	Condo 202)		10f. Zip Code	21236		10g. Citizen o	f What Cou	untry'?	
	nth wit	nue	4 Juliet Lane (edent Ever in l	J.S. 13. V	Was Decedent of H		? (Specify Yes or No- ruerto Rican, etc.)		ace - Amer	ican Indian,	
5	er dez or ite miner	by F	1 Never Married 2 Marri	Armed F	orces?		f Yes, specify Cub ☐ Yes 2 X XNo		uerto Rican, etc.)		ack, White		
3	urs aff ural", al Exa		3 Widowed 4 Divorced	If Yes, G Year or I	oates.						∌: Wh:		
5	72 hoi n "nat ledica	Completed	15. Deceden (Specify only highes	st grade complete		(Give	lent's Usual Occu kind of work done O NOT use retired	during most of	f working	16b, Kind of	Business i	naustry	
7	filed within 72 hours after death with the Maryland of the great than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at went, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4 or 5+) A	<u>Wai</u>	tress			Restua	rant	Industry	
ם מום	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "hatural", or items 23a or 28a-f show item 27 is marked other than "hatural" or items to notified at other traumatic event, the Medical Examiner must be notified at.	To Be	17. Father's Name (First, Middle, La Henry Comes	ast)					s Name <i>(First, Middle</i> na Fernkas		me)		
	should I and Me is marl raumati		19a. Informant's Name/Relationsh				ng Address (Street		or Rural Route Numbe				
າ ນົ	and 2 s Health tem 27 other tr		Thomas M. Butle: 20a. Method of Disposition			. Place of Dispo	sition (Name of		Date	20c. Locatio			
Ē	age 1 ent of nt: If i		1 ☐ Burial 2xxxCremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal fro pecify)	m State Me		matory or other pla matory I		11-9-2009	 Baltin	nore,	Md.	
baltimor	permit, Page 1 and Department of Hamportant: If ite any injury or of once.		21. Signature of Funeral Service U				2. Name and Addr .assahn F			l Belai			
ם			23a, Part 1. Enter the disease, or	280ml	t caused the d				Dai	timore,	Ma.	Approximate	
١,	esconer.	l,	shock, or heart failure. List o	nly one cause on	each line.		or the mode of dy	1100	~ = 10 <i>a</i>			Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	a. Due t	o (as a cons	equence of):	04	TU	YACIDICE	N. Con		ident	
	Examiner	er	Security list conditions if any, leading to immediate	b. Due t	o (or as a cons	カタ equence of):			1 1 0	A CAL ELANIBER		9/21/2	
	executed an and rial-transit	Examin	cause. Enter Underlying Cause (Disease or linjury that initiated events	c					J. Die Bin	<u></u>			
		_	resulting in death) Last	Due t	o (or as a cons	equence of):	uence of):						
Box 68/60	certificate be nding physici use as the bu	ledic		d				10	VELOW.				
Š	ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths?	1 🔲 Liv	outcome of pre-	etal death 3	Ectopic pregna	ncy			Date of de Month	livery Day Year	
9	that the death ned by the atte edetached for	Physician/Medical	1 Yes 2 No 9 Unknown	4 ∐ Pr 9 □ Ur	egnant at time nknown	of death 5 l	Other (specify)						
J.	that the ned by detac	by Ph	Part II. Other significant condition	ons contributing to	death but not	resulting in the	underlying cause	given in Part I.		1.7		the cause of death?	
	law requires nas been sign e 2 should be	ted										robably 4 Unknown	
Records,	aw 1as	Completed								s an 24 opsy formed? s 2 MNo	prior to death?	completion of cause of	
Ä	sician; The la certificate ha irector, page 2		25. Was case referred to medical				26.	Place of Death	1 \(\text{Yes}\) (Check only one)	2 2 N No	1 ∐ Ye	s 2 🗆 No	
Vita	ysicia is cert directu	To Be	examiner?	Hospital:	☐ Inpatient 2	☐ ER/Outpatie	ent 3 LIDOA	ther: 4 \square Nurs	sing Home 5 🗆 Res	sidence 6	Other (Spec	city) NOSDICE	
o	ing Ph ifter th uneral		27. Manner of Death 1. Natural 5 Pendir	og (M	te of injury onth, Day, Year) injury		uryat ork? ∐Yes 2 X N	28d. Describe	messed	Fa II		
Sion	ottend death ctor: A y the f	Certificate:	2 Accident Investi 3 Suicide 6 Could	not be 28e. Pla	ce of Injury - A	t home, farm, st	reet, factory, office		28f. Location	(Street and Nui		ural Route Number,	
Division of Vital	al or A s after Il Direct		4 Homicide determ	bui	lding, etc. (Spe	ASISTED	LIVING FAC	ILIM	8101 Bc			WSON MO	
1	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate F completed filled in by the funeral director, page	Medical	(Ot and Of Blackhoot I	Evaminari On tha	ageie of evamin	ation and/or inve	stigation in my onl	nion, death occ	lace, and due to the curred at the time, date	e and blace, and	que to trie	Cause(s) and manner stated.	
1	o the lotth 2 the lotth 2 the lotth 2 omple	ž	only one) 3 Certifying 29b. Signature and title of certifie		er: To the best o	f my knowledge.	29c. Licer	ise number	and place, and due to	29d. Date sig	gned (Mont	th, Day, Year)	
	F S F O		> Alranh	7			109	8303		Noremb	u 5	2009	
	5		30. Name and address of person	who completed co	ause of death (tem 23a) (Type,	Print) Parles &	T TO	VSON NO				
	Sta	ate	31, Date filed (Month, Day, Year)	32	egistrar's Si			1		<u></u>			
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wrence Bettes		State of Maryland / Department of Certificate of Certificate		ind Mental H		g. No. 200	9 3641		
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	- Dodin		2. Date of Death	1	3. Time of Death		
edical Exami		Lawrence Bettis Lawrence Betti			Month November		0225 hrs		
		4a. Facility Name (if not institution, give street and number) SB 4200 Block of Route 5	4b. City, Town, Temple H	or Location of Death	1	4c. County of Death Prince George			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	if Under 1 Y	ear If Under 24Hr	s. 8. Date of Birth		thplace (State or Foreign		
Director		577 06 4619 1 M 2 F 37 Yr		ays Hours Mir	Jan 7,	1972 Wa	untry) Ashington DC		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ition				10d. Inside City Limits		
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darylar 28a-f s 1 at on	Director	10e. Street and Number	10f. Zip Code	9	10	g. Citizen of What Cou			
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0 = = - = 1		17. Father's Name (First, Middle, Last)	I laiden Surname)	ne)					
ID 21215-0036 2 should be filed within 7 1 and Mental Hygiene. 27 is marked other than matic event, the Media	o Be	Lawrence M. Bettis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Maillin	rring iber, City or Town, State	e Zin Code\					
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Mee Important: If item 27 is man injury or other traumatic ev	ř		lboro, MD 2						
re, h Healt Fitem er trav		20a. Method of Disposition 1 XX Jurial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or or company or compan			Date 14,2009	20c. Location - City or	r Town, State		
Baltimore, bermit. Pages I an Department of Hee Important: If iten		4 Dogation 5 Other Specify: Trinity		Gardens		Waldorf,			
Balt permit Depart Impor injury		21. Significant of Funer I Service Licensee 22. All	Name and Addr	ess of Facility Lee	Funeral	l Home, Inc	.6633 01d		
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dyi	ng, such as cardiac	or respiratory arre	nton, MD 20 est, shock, or heart	Approximate Interval		
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries					Between Onset and Death		
· (ammor		or condition resulting in death) Due to (or as a consequence of):							
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<u>a a a c</u>	ledic	UNPENDED #1 per ME g89 IF FEMALE: 23c. If yes, outcome of pregnancy	7 11.13	.09 TT		23d. Date of deliver			
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Division of Vital Records, P.O. I Hospital or Attending Physician: The law requires that the 24 hours after death, divided the securificate has been signed by the Funeral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached.	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		Othor		Residence 6 🗸 Othe	er: Scene		
ing Ph After funeral	T:uc	27. Manner of Death 1 Natural 5 Panding FOUND: 28a. Date of Injury FOUND: FOUND: FOUND:		Injury at Work?		how injury occurred struck by auto			
Division tal or Attendir rs after death. al Director: A	icati	2 Accident Nov 9, 2009 0217 hrs Nov 9, 2009 0217 hrs 28e Place of Injury - At home, farm, str		Yes 2 No	28f. Location (5	Street and Number or R	tural Route Number, City		
Divisior ospital or Attend hours after death neral Director:	Suicide or Town, State) or Town, State) or Town, State) south bound 4200 block route 5, Temple								
To the Hospita within 24 hours To the Funeral Completely fille		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occ	urred at the time	, date and place, ar	nd due to the caus	se(s) and manner as sta	ated.		
To the within. To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated. 29b. Signature and title of certifier		ense number	at the time, date	29d. Date signed (M			
		Calman stars		C.M.E.		November 9, 20			
		30. Name and address of person who completed ca e of death (Item 23a)							
			enn Street, B	altimore, MD 2	1201				
St Regis		31. Date filed (Month, Day, Year) 32. Degistrar's Signature	- A. D						

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		Registrar 1. Decedent's Name (First, Midd	lle, Last)		Cer	tificate of	Death		2. Date of De		009	364 3. Time of Deat	3
Physicia /Medic		Georgianna W	Bryant						Octobe	r 31,	2009	9:07 AM	М
Examin		4a. Facility Name (If not institution				4b. City, Town,		Death			ounty of Deatl		
		Seasons Hosp 5 5. Social Security Number		st Hosp: Age (In yrs. las		Randa1		4 Hrs. T	8. Date of Bi		altimon	enplace (State or Fore	nian
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Maryland I-f show fied at	tor	10a. State 10b. County MD Balts		10c. City,	Town or Loc	timore						10d. Inside City Lim 1 ☐ Yes 2√2	
th the or 28s	Director	10e. Street and Number		1		10f. Zip Code				10g. Citize	en of What Co	untry?	
ath wi	ral	3309 Ripple Ro					1244			US.			
s after deg	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Mar 3 □ Widowed 4 □ Divorce	If Yes, Give	s? XINo		Vas Decedent of fYes, specify Cul	oan, Mexican, i	in? (Sp€ Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: b1	, etc.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, The Medical Eventher must be notified at once.	Completed	15. Deceder	nt's Education est grade completed) College (1-4c		16a. Deced (Give life. L	lent's Usual Occu kind of work done OO NOT use retire	pation during most o	of workii	ng	16b. Kind	d of Business/I	ndustry	
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hould of Mer marke matic	은	19a. Informant's Name/Relation:		<u> </u>	10h Mailin	a Address (Stree			Elizab			in Code)	
nd 2 saith ar 27 is r trau		Randolph Brya				Ripple					1244	ip Godo)	
Pages 1 a nent of Hea nt: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (5		Cen	ce of Disponetery, cren	sition (Name of natory or other pla	ace)	D	ate	20c. Loca	ation - City or	rown, State	
permit. Departm Importa any inju		21. Signature of Funeral Service Ronal d	Vicensee 0//	rector	St	Name and Addi ate Anat 1timore,	omy Bo	ard 1201	655 W	. Bal	timore	Street	
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uires that t signed by d be detad	by	Part II. Other significant condit	ions contributing to death	n but not resulti	ng in the ur	nderlying cause g	iven in Part I.				e contribute to	the cause of death	
The law requate has been page 2 shoul	Completed								24a. Was auto perf 1 □ Yes		prior to death?	topsy findings availa completion of cause 2 No	
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To the within To the complex c	M	29b. Signature and title of certification.	Demi D			Į.	nse number 200574			10	signed (Monti	9.	
		30. Name and address of person N S Raja S 31. Date filed (Month, Day, Year NOV 1 3 2003	who completed cause of	of death (Item 2	ain St	Print) Suite	200, M	leis	terstoi	Nn,	ND. 2	21136	
Sta Registr		NOV 13 2005	32. Regi	strar's Signatur	ark								

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36414 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 5, 2009 **Physician** Dolores F. Baraty <u>21:4</u>0 P^M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center <u> Air</u> 9. Birthplace (State or Foreign Country)
MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 10/21/1928 Security Number **Funeral** Min. Months Days Hours 1 ☐ M 2 💢 F 213-26-7198 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show e notified at 10a. State 10b. County 1 ☐ Yes 2X No MD Baltimore Halethorpe Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or must be r 21227 USA 5834 Oakland Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natu vent, the Medical Elementary/Secondary (0-12) College (1-4or 5+) 12 sewing machine operator Schroder Co. traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi. h and Mental H Be John Czyzia Margaret Kar©zewski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an S 5834 Oakland Road Baltimore MD 21227 Donna Wells - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 11-12-2009 Glen Burnie MD Atlantic Crematory 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21 Signature of Juneral Service Licen Ambrose Funeral Home 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongestive disease or condition resulting in death) /Medical Due to (or as a coverequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for his a consequence off: Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknowr 9 ☐ Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2000 24a, Was an cate has by page 2 s certificate Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/2 1 patient 2 ER/Outpatient 3 DOA 10 Division or After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

3

Nuhamnaa

1 3 2009

31. Date filed (Month, Day, Year)

500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Toblesday,

32. Registrar's Signature

D60768

Upper Chesapeake Dr., Bellir.

Theodore Edward 09-08587 Boone

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK		State of Maryland / Department of 1-For State Certificate of		ygiene Reg. N	. 200	19 3641	
Physician	n/	1. Decedent's Name (First, Middle,Last) Theodore Edward Boone		Date of Death Month Da	y Year	3. Time of Death	
Medical Examin		E CONCONTE DO SIL	b. City. Town, or Location of Death	Month Da November 4,	2009 4c. County of Death	2000 hrs	
		4a. Facility Name (if not institution, give street and number) 4 3700 Cottage Terrace	Cottage City		Prince George		
Funeral	7	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	 `	IM/DD/YYYY) 9. Bir	thplace (State or District of	
Director	1	219-80-6752 1×m 2 F 47 Yrs.	Months Days Hours Min	08/19/19		olumbia	
y.	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatic	on .			10d. Inside City Limits	
ow any						1 Yes 2 No	
Aaryland 28a-f show	흱	Maryland Prince Georges Mount R	ainier 10f. Zip Code	10g.	Citizen of What Cou	ntry?	
ith the Maryland 23a or 28a-f sho notified at once	[급	3502 Bunker Hill Road	20712	Un	ited Stat	es	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	s Decedent of Hispanic Origin? (Sees, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,	
r death	핊	1 X Never Married 2 Married 1 Yes 2 X No	Yes 2X No specify:	,	Specify: Wh	ito	
ural",	<u>a</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	's Usual Occupation (Give kind of		b. Kind of Business		
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use ret				
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)	Beatric	•	ddle, Maiden Surname)		
212 ould be Menta marke	To Be	James F. Boone, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or		r, City or Town, Stat	e, Zip Code)	
MD nd 2 sho alth and an 27 is		Beatrice Boone/ Mother 3502 H	Bunker Hill Road		inier, Maryl	and 20712	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours at nent of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposic crematory or oth	iei piace;	ancer II,	Oc. Location - City o		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Departion 5 Other Specific Metro Crema	tory, Inc. 200		Baltimore, N	•	
Balt Sermit. Separti Importi		21. Signature of Funeral Service Licensee Amanda Heaston	lame and Address of Facility rem	ation Societ	y of Maryla	ind, Inc.	
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	Frederick Road, Bal	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and	
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple injuries				Death	
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uted nd ransit	шĬ	events resulting in death) Last Due to (or as a consequence oi): d					
f Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed er this certificate has been signed by the attending physician and and director, page 2 should be detached for use as the burial - transit	edical	X UNPENDED X AMENDED 11, 23a,27,28a-	f.perME, g899 1	/8/10 TT			
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Box 6876 e death certificate the attending phy ed for use as the?	cian	past 12 months? 1 Live birth 2 Fe 4 Pregnant at time of death 5 Ot	tal death 3 Letopic pregr her (Specify)	laircy	WIGHT	Day	
Boy e deatl the att	Physician/M	1 Yes 2 No 9 Unknown g Unknown		22a Did toba	ess use contribute t	o the cause of death?	
Division of Vital Records, P.O. Box 6876 tal or Attending Physician: The law requires that the death certificat rs after death. 31 Director: After this certificate has been signed by the attending physel in by the funeral director, page 2 should be detached for use as the	2	•	inderlying cause given in Part I.		2 ✓ No 3 Pr		
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cor e law r e has b	ם			autopsy performe	ed? death?		
Re Ir Pe	ပိ		26.Place of Death (Checi		110	163 2 110	
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n of ing Pt	Ţ.ï	27. Manner of Death 1 Natural 5 Ponding (Month, Day, Year) 28b. Time of I	Injury 28c. Injury at Work?	28d. Describe how	winjury occurred struck by	train	
Sion Attend death. sctor:	catic	Pending Investigation Investigation Ptd 1/4/09 Ftd 7:5: 2 X Accident Ftd 1/4/09 Ftd 7:5: 28e. Place of Injury - At home, farm, stre	3 pm				
Division spital or Attent ours after death eral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) train track		or Town, Stat	e 3700 Cot	Rural Route Number, City Etage Ter	
<u></u>			rred at the time, date and place, ar	nd due to the cause(s) and manner as st	ated.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(check only one) 2 Medical Examiner:On the basis of examination and/or investiga and manner stated.	tion, in my opinion, death occurred	at the time, date an	d place, and due to	the cause(s)	
F * F 8	ž	29b. Signature and title of certifier	29c. License number		29d, Date signed (A		
		Yamel Buthell, MI)	O.C.M.E.		November 5, 2		
Oran		30. Name and didress of reson who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 11	1 Penn Street, Baltimore,	MD 21201			
Sta	ate		barker				
Regist		1101 1 2 2000 / June 4. 14	C. C				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	oi iviaryiani	•	artment of He tificate of De		•			
			Decedent's Name (First, Middle, Last)			anoate or D	<u>cuiri</u>	2. Date of Dea	Reg. No. 2005	3.64.16	
	Physicia		Ian Andrew Baggett Sr	•				Novemb	er 12. 200	9 8:34 AM	
gg/c,	Medic Examin		4a. Facility Name (if not institution, give street and nu			4b. City, Town, or L	ocation of Death		4c. County of Dea		
			2816 Kaywood Place			Sykesvil	le		Carrol:	1	
	Funeral		5. Social Security Number 6. Sex 17 - 90 - 0.301 1 M 2 F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		thplace (State or Foreign puntry)	
	Director		217-80-9301 1 A M 2 L F Usual Residence of Decedent	4	48 Yrs.			Aug 4,	1961 Mai	iné	
	ind show at	١	10a. State 10b. County	10c. City	, Town or Loc	cation	_			10d. Inside City Limits	
	faryle 3a-f s tified	Director	Maryland Carroll		Sykes	ville				1 ☐ Yes 2 ☒ No	
	or 29		10e. Street and Number	<u> </u>		10f. Zip Code			10g. Citizen of What Co	ountry?	
	with s 23a ust b	Funeral	2816 Kaywood Place			21784			USA		
	death item	Fun		edent Ever in U.S	. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Sp	ecify Yes or No-	14. Race - Ame		
336	s after (al., or Examir	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, G 3 ☐ Widowed 4 ※ Divorced Year or E	ive 2X No		1 ☐ Yes 2X No Specify:			Black, Whit Specify: Whi		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed		16a. Deced	ent's Usual Occupat and of work done du	ion ring most of work	ina	16b. Kind of Business	Industry	
121	rithin 7. iene. r than	Com		1-4 or 5+)	life. DO	inessman	mig moot of from	9	Self En	mploved	
pu	iled will Hyg		17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surname)	<u> </u>	
/lar	d be f Menta arked atic e	ပ	Dana R. Baggett				Judit	h Beckl	er		
lan	shoul and l is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street an	d Number or Run	al Route Number	, City or Town, State, Zi	p Code)	
2	ind 2 lealth im 27 her tr		Dana R. Baggett, Fathe				Road Ba	iley Is	land, ME 04	4003	
O.	ge 1 and to 1 filter in the control of the control		20a. Method of Disposition 1 □ Burial 2 【 Cremation 3 □ Removal from	n State Ce	metery, crem	sition (Name of natory or other place)	1	Date	20c. Location - City or		
Baltimore,	it. Pac		4 Donation 5 Other (Specify)			matory In			Baltimore	•	
Ba	permi Depar Impol any ir		21. Signature of Funeral Service License Thomas	as Gregor	r 2	remation 99 Freder	Society ick Roac	Of Mary l Baltim	land, Inc ore, Maryla	and 21228	
П			23a. Part 1. Enter the disease, or complication; that shock, or heart failure. List only one cause on e	ach line.	. Do not ente	r the mode of dying,	such as cardiac	or respiratory arr	est,	Approximate Interval Between	
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	C	0100	cance				Onset and Death	
5.05	Examiner		Due to	(or as a conseque	ence of):						
	-	ner		(or as a conseque	ence of):						
	icate be executed g physician and is the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or impury that initiated events c.								
	ficate be executed g physician and as the burial-transi	Ě	resulting in death) Last Due to	(or as a conseque	ence of):						
3760	te be nysici he bu	dica	d								
387	rtifica ing pl	/Me	IF FEMALE:								
×	ath ce	ian	in the past 12 months?	itcome of pregnan Birth 2☐ Fetal gnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year	
P.O. Box 68	requires that the death certificates signed by the attending postbooling be detached for use as	by Physician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pre 9 ☐ Unknown 9 ☐ Unk		eatn 5∟	Other (specify)			Worth	Day Ica	
P.0	that the	y Pt	Part II. Other significant conditions contributing to	death but not resu	Iting in the ur	nderlying cause giver	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
Š,	uires n sigr	ed b						1 🗆 ነ	′es 2 No 3 □ P	robably 4 🗆 Unknown	
Ö	w req	plet						24a. Was a		topsy findings available	
3e	The la	Completed						autop perfor 1 🗆 Yes	med? death?	completion of cause of	
B	sian: artifica ctor, p		25. Was case referred to medical examiner?	17		26. Plac	e of Death (Chec		2 (2) (10)	2 2 110	
₹	hysic his ce	ျာ	1 Yes 2 No	Inpatient 2 🗆 E		t 3 DOA Other:	4 Nursing Ho	ome 5 Resid	ence 6 🗆 Other (Spec	ify)	
٥	ling P	ate:	TE Natural 3 Pending	of injury oth, Day, Year)	28b. Time of injury	28c. Injury a work?		28d. Describe ho	ow injury occurred		
Sior	death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At hon	ne farm etre		es 2 🗆 No	Oof Leasting (C)			
Division of Vital Records,	alor A s after I Direct			ling, etc. (Specify)	ne, iaim, sile	et, lactory, office		City or Town	treet and Number or Ru n, State)	rai Houte Number,	
_	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	edical	29a. Certifier 1 Certifying Physician: To the 2 Medical Examiner: On the ba	sis of examination	and/or investi	gation, in my opinion,	death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated.	
	o the	Σ	only one) 3 L Certifying Nurse Practioner: 29b. Signature and title of certifier	to the best of my	knowledge, d	eath occurred at the t 29c. License n			cause(s) and manner as 29d. Date signed (Monti		
			m rul htto					4	11/12/	1	
	151		30. Name and liddress of person who completed cau			rint) C 1 D	4085	<u>.</u>	Bultimon	2:	
	Stat		31. Date filed (Month, Day, Year) 32.	Sedistrar's Signatu	327	1 57, 4	aut Tra	4	newstines	21202	
	Stat Registra		NOV 1 3 2009	Denne	A. A.	CAME					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Betty Jean Barrett Y°8°C1 22:25 M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Talbot Easton Hospital taston If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-24-7905 1 □ M 2 🔀 F 80 Months Davs Hours (Month, Day, 2 _ 1 1 _ Country)
Maryland Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State MD Talbot with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Easton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 W Earle Ave. "natural", or items 23a 21601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify. Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Bookeeper Hospital 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any fijury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Carpenter Nettie Mae Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Place - daughter 1164 Regina Elena Ave., Vineland, NJ 08360 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem Park 11-14-09 Sykesville,MD 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licens 22. Name and Address of Facility Fletcher Funeral Home Komas 254 E. Main St. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician. watremie disease or condition resulting in death) Medical a nsequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ Nor 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed 2 No Yes 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes မ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe D0053 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

DeShields MD,

32. Registrar's

Dennis

3

31. Date filed (Month, Day, Year)

219 S. Washington St., Easton, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36418 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1704 M Gwendolyn Anderson Broadie NOVEMBER 060 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AGNES BALTIMORE If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Months Days Hours 1 □ M 2 □ F 217-66-8540 Nov 9 1955 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Md. N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1836 Hope Street 21202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □No Specify 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Freddie Anderson Mary Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freddie Anderson 4028 Westchester Road Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/13/09 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part f. Enter the dise se, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ardiac arry thmin 2 minutes disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) ne of pregnancy n 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hemorhage

Physician /Medical

Physician

/Medical

Examiner

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Funeral

Director

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within 72 hours after

Maryland 21215-0036

Baltimore,

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Box

P.O.

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Vital

of

Physician:

Hospital or Attending Division

24 hours after death.

Funeral Director: /

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event, the Medical Examiner must be notified at

Director

Funeral

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Completed

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Examiner requires that the death certificate be executed sician and burial-trans

Examiner

Physician/Medical

à

Be Completed

Certification: To

Medical

State

Registrar

attending pl the detached g page 2 should certificate director. this funeral After

FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr

Hypertension

5 Pending investigation

6 Could not be

determined

24a. Was an autopsy performed

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown

1 □Yes 26 Place of Dooth (Chack only one)

Were autopsy findings available prior to completion of cause of death? 214

							,			
OA	Other:	4 [Nursir	ng H	ome	5 ☐ Res	idence	6 [Other	(Specify)
28c.	Injury at Work? 1 □ Yes		2 □ No			Describe				

Meghan Checkley

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

↑☐ Certifying Physician: To the best of my knowle 2☐ Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, and of and/or investigation, in my opinion, death occurred at	due to the cause(s) and manner as stated. the time, date and place, and due to the ca
title of certifier	29c. License number	29d Date signed (Month Day Y

dea BC 9916795

29d. Date signed (Month, Day, Year) November 6, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore, Maryland 21229 South Caton

3 Date filed (Month, Day, Year) NOV 12 2009

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1☐ les 2☐ No

27. Manner Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only one)

32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day, Year)

2 R/Outpatient 3 DOA

28b. Time of

Injury

			For State	State of Maryla				lental Hygi	ene			
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2. Date of Death	g. No. 200	3649		
п	Physicia		Margaret H.	Cipyak				Month Nov.	Day Year 2009	4:01 P M		
mer _{le}	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of Death		4c. County of Death			
			Shady Grove Adven			Rockvil			Montgome			
	Funeral Director		5. Social Security Number 6. Sex 178-01-1094 1□	M 2 ★ F 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 18	Year) 9. Birt Co	hplace (State or Foreign untry) ONSYIVANÎA		
	and w		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	cation				10d. Inside City Limits		
	Maryla -f sho	ō	Virginia Fairfax		lcLean					1 □Yes 2X No		
	r 28a	irec	10e. Street and Number	177	CLCUII	10f. Zip Code		10	g. Citizen of What Co	untry?		
	th with	ral D	800 Towlston Road			22102			USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exa ultra mast be rediffied at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cub 1 □Yes 2 🏿 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W			
21215-0036	72 hou 'natura	eted	15. Decedent's Educa (Specify only highest grade)	tion completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	ing 1	6b. Kind of Business/	Industry		
121	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire E maker	d)		Own Hon	n a		
9	i filed i Hygi other ent,	Č	17. Father's Name (First, Middle, Last)		Honic	maker	18. Mother's Name	e (First, Middle, M		<i></i>		
Maryland	uld be Menta Irked Itic ev	To Be	John Haluska				Mary C	Chizmar				
lar)	2 sho and is ma is ma	•	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number,	City or Town, State, 2	Zip Code)		
e,	1 and Health em 27		Jainel Morris/Daug. 20a. Method of Disposition	hter 20h	800	Towlston	Road, M	cLean, V	/a. 22102 Oc. Location - City or	Town, State		
mor	Pages ent of nt: If it		1 ☐ Burial 2 【XCremation 3 ☐ Real 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Mo	ney &	sition (Name of natory or other plac KING ON Servic	De) // //	15 2/109	01 1311			
Baltimore,	rmit. F partm portar y injui		21. Signature of Fongra Service Licensee			2. Name and Addre	is of Facility		Chantilly,			
<u> </u>	8 8 E 8 8		Gary R. Downer	k King Fu aple Ave.	ineral Ho , Vienno	ome, Inc.	180					
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Appiration Pneumonia a. Due to (or as a consequence of):									
8760, 🗗	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, than, leading to transclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Dise to (or as a conse	equence bij	_						
P.O. Box 68	The law requires that the death certific attending p ate has been signed by the attending p age 2 should be detached for use as a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _		livery Day Year				
	e law requires that has been signed be e 2 should be det		Part II. Other significant conditions control Respiratory Failure		-				acco use contribute to s 2 X No 3□ P	o the cause of death? robably 4 ☐ Unknown		
COL	s beer shoul	Completed by	Hypertension					24a. Was an	24b. Were au	utopsy findings available		
<u>~</u>	The Is ate ha	mo						autopsy perform 1 □ Yes 2	ed? death?	completion of cause of 2 □ No		
/ita	ician: The certificate ector, pag	Be (25. Was case referred to medical examiner?			Leu		h (Check only one				
Division of Vital Records,	ding Phys n. After this funeral dii	Certification: To	1 ☐ Yes 2 💢 No Pro 27. Manner of Death 1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigation	spital: 1 💢 Inpatient 2 28a. Date of Injury (Month, Day, Year)	28b. Time of	28c. Inju Wor	4 LI Nursing Ho	ome 5 ☐ Resider 28d. Describe how	nce 6 ☐ Other (Spe w injury occurred	ecify)		
Divisi	To the Hospital or Attentwithin 24 hours after deatt To the Funeral Director: completely filled in by the	Sertifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, streetify)	eet, factory, office		28f. Location (Stra City or Town,	eet and Number or R , State)	ural Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		cian: To the best of my ker: On the basis of exami and manner stated.								
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mont	th, Day, Year)		
		115	Marille	MMG	,	Vaou	99336	IN	lovembe	18,2009		
	6		30. Name and address of person who compared to N. William				ter Dr.,F	O-F-10	, Md. 208			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature Barke	0		<u>. </u>				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 2, 2009 Year 1:50 Рм Patricia Cronise 4b. City, Town, or Location of Death Baltimore 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore 4023 Colchester Road Apt 185 8. Date of Birth (Month, Day Year) 11-26-1947 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 1 □ M 2 🔀 F Min. Months Days Hours 217-46-3687 61 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No MD Baltimore Halethorpe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4023 Colchester Road Apt 185 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: white If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security account rep. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norma Jean Millikin William Charles Cronise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1046 Downton Road Halethorpe MD 21227 Jeffrey Cronise-son 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) T⊟Burial 2 XCremation 3 ☐ Removal from State Nov. 5,2009 Glen Burnie Atlantic Crematory 4 Donation 5 Sther (Specify) Signature 1 Funeral Service Licen 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterio Scherotic Cardio Vascular Disease Immediate Cause /Final disease or condition resulting in death) Due to (or as a consequence of): ertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (pras a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

ir than "natural", or items 23a or

and 2 should be filed within 72 hours after theath and Mental Hygiene.

m 27 is marked other than "natural", or iter her traumatic event, Its Medical Examina.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Physician/Medical þ Completed Be (Certification: To

2 Accident

4 Homicide

3 Sulcide

29a. Certifier

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐Yes 2 ☐No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) and manner stated. 29b. Signature and title of certifier ark

6 ☐ Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) November 4, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3455 Wilkens Ave Baltimore, MD 21229 AMBANDAM BASKARAN

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature 13 2009

24 hours a

To the Hosp within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36421 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** November leman 4:00 PM 2009 oone /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Baltimor Nursing Home If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 -24-6716 Marylana Director tober Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show injury or other traumatic event, the Medical Evangner must be notified at 1 Nes 2 No Funeral Director tanover 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō Pages 1 and 2 should be filed within 72 hours after death with 1076 2 "natural", or items 23a 100 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 ₩0 Blac _ 6 If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than Manpower 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Iderdale Son oleman <u>ional</u>a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If Ite
any injury or ot or other place 1 Surial 2 Cremation 3 Removal from State 19/09 Jarrison torest <u>JWI</u>ngs 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fluxeral W. Balto. 4650 Li berty Heights 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PARKINSONIAN DEMENTE **Physician** DURNC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinitellate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 2 🗌 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2, To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1761C

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 200 **Physician** acee 910 NOVEMBER /Medical 4b. Sity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BAYVIEW MEDICAL CENTER JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 6, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland Months Days Hours 1 □ M 2 🖫 F Dec. 33 Director 216-92-1806 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director Baltimore Sparrows Point Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21219 2820 Lodge Farm Road United States 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☑ No Specify: Black ģ Specify: 3 Widowed 4 Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the INs any Injury or other traumatic event, the INs office. Elementary/Secondary (0-12) College (1-4or 5+) 12 Healthcare Nurses Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cole Cynthia Owens Eugene ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6607 Loch Hill Road, Baltimore, Maryland 21239 Regyna Cooper/ Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) November 11. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Mary arc, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OR ESPIRAT Physician 2 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner spital or Attending Physician: The law requires that the death certificate be executed fours after death.

reral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) TYes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? pe rform 2 No 1 ☐Yes 2 No 1 ☐Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 29a. Certifier l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE, BALTIMORE, MD ZIVENS, (MOMY

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MALIC 2009 ma /Medical 4a. Facility Name (If not institution, give street and number 4b City Town or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Tizabeth Rehab 8 Nursia Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 3208418 10 M 20F Months Days Hours Director 84 10, 1925 Maryland Usual Residence of Decedent the Maryland 10a, State 10b County 10c. City. Town or Location 10d. Inside City Limits show ?? is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Medical Examiner must be notified at Director 1¥7 Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3310 Benson 21227 Funeral Avenue United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 K No ģ Specify Specify: B Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental William E. Taylor Estelle Withers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 4784 Melbourne Road, Baltimore, Maryland 21229 Carolyn Lowe/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 November 12 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility Cremation Society of Maryland, Inc 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore. Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician OPD /Medical Due to (or as a consequence of): Examiner dementa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit h-100+h-1001dis execu Due to (or as a consequence of) P.O. Box 68760, attending physician certificate be Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
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1 □ Yes 2 □ No 24a. Was an performed certificate 1 □ Yes 2 **1**0 No Hospital or Attending Physician; 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Wursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🛂 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation in 24 hours are:
the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CPLO 11112109 12111615

Registrar
DHMH 17 Rev 1/2001

State

3320

Benson Ave

Baltmore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

(scidsborough

32. Registrar's Signature

09-08605

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Mar	yland / Depar	tment of He	alth and Me	ental Hygien

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Physicia		Registrar 1. Decedent's Name	e (First, Middl	e,Last)		uncate	JI Dea	un			2. Date of Dea	eg. No.		3. Tim	e of Death
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4				n, give street and nu edical Center	mber)		4b. City, Bel	Town, or L Air	_ocation of	f Death			County of I	Death	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs. I	ast birthday)		If Under 1 Year If Under 24Hrs			8. Date of Birth(MM/DD/YYYY) 9. Bi			9. Birthplace oreign	(State or
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Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumartic event, the Medical Examiner must be notified at once.		11. Marital Status		12. Was Dec	edent Ever in U	. S . 13. V		ent of Hisp	oanic Origi		pecify Yes or No- 14. Race - American Indian			ian, Black,	
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4		or condition resulting	ng in death)	Due to (or as a	consequence o	of):									
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Box 6876 e death certificate the attending phy ed for use as the L	Physician/M	past 12 months		4 Pregn	ant at time of de	oth -	Other (Sp		Lotopic	pregnan	Су		World	Day	Teal
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Records, P.O. Box 6876 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the t	ξ	Part II. Other signi	ficant conditi	ions contributing to	o death but not r	esulting in the	e underlyir	ng cause gi	iven in Pai	rt I.					use of death?
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		25. Was case refer	red to medical					26.Place	of Death (Check o	1 Yes	2 N	10	✓ Yes	2 No
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tendi tendi death.	atio	1 Natural 2 Accident	5 Pend					1Y	es 2	No					
Division of Vital Records, the Hospital or Attending Physician: The law require hin 24 hours after death. The Funeral Director: After this certificate has been simpletely filled in by the funeral director, page 2 should by	Certification:	3 Suicide	6 Coul	d not be 28e. Plac	e of injury - At h	ome, farm, st	reet, factor	ry, office bu	uilding, etc	c. i	28f. Location or Town,		and Number	or Rural Rou	ite Number, City
Spita hours		4 Homicide 29a. Certifier		mined (Specify)				Sava							<u>-</u> .
Division Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only		nysician: To the bes miner:On the basis	of examination a	-									e(s)
vit To Con	Me	29b. Signature and	title of certifie	and manner s	tated.		2	9c. License	e number			29d.	Date signed	(Month, Da	y, Year)
		(00	west	DILLO)			O.C.N	И.E.			Nov	vember 6	, 2009	
	ŀ	30. Name and addre	ess of person	who completed caus	se of death (Item	1 23a)							-		
		Laron Locke		ssistant Medica		111 Per	n Stree	t, Baltim	nore, Mi	D 2120)1				
St Regist	ate	31. Date filed (Mont	h, Day Year)	32. Re	egistrar's Signatu	Jre A	20								

To the within to the coming of the property of	Me
Sta Registr	
DHMH 17 Rev 1/2	001

		For State		State	of Maryla		epartme Certifica			nd Me	ntal Hy	giene Reg. No.		n 9	364	25	
		Registrar 1. Decedent's Nam	ne (First, Midd	le, Last)							Date of De	ath			3. Time of De		
sicia edic		Aı	rta Ca	roline :	Pirpi	tsaki					Moven	nber	13,	2009	12:45	Ам	
min	er	4a. Facility Name (n, give street and no	ımber)		4b. City		r Location of D Limore	Death		4c.	County of Balt	f Death	ce		
ral		5. Social Security N		6. Sex	7. Age (In y	rs. last birtho		er 1 Year	If Under 24	Hrs. 8	Date of Bir (Month, Di	th		9. Birthpl	ace (State or F	oreign	
tor		216-24-7		1□ M 2 X F	3	30 Yrs	S. Months	s Days	Hours	Min.	lay 31	,192	9 1	Mary.	land		
43		Usual Residence of 10a. State	of Decedent 10b. County		10c.	City, Town o	r Location							11	Od. Inside City I	Limits	
	tor	MD		Baltimore			Bal	timo	re			1 □Yes 2 X No					
1	Director	10e. Street and Nu					10f. Z	ip Code	26			10g. Citi	10g. Citizen of What Country?				
100	ral	5 Lark	Meadow			21236							USA				
TO SERVICE	by Funeral	11. Marital Status		ried Armed F	2 🙀 No ive	If Yes, specify Cuban, Mexican, Puerto Rican, etc.))-	 Race Black, Specify: 	, White, e			
1	ed b	3 Widowed		Year or I	Dates:	16a. D	ecedent's Us	ual Occur	ation			16b. Ki	nd of Busi				
NO.	plet	(Spe	cify only highe	1-4or 5+)	- (G	Give kind of wife. DO NOT	rork done use retired	durina most o	of working		1	er Ma		•			
	Completed	8				Accountant											
2	To Be	17. Father's Name (First, Middle, Last) Charles W. Hart 18. Mother's Name (First, Middle, Maiden Surname) Anna Marie Lorden)					
na n		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7841 Fernhill Avenue-Pasadena, Maryland 21122															
5 6 6		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	Cremation	3 ☐ Removal from Specify)	crematory or neral Cr	sition (Name of pate 20c. Location - City or Town, State al Charlet and Pov. /3, 2009 Forest Hill, Maryland er. Belair											
once.		21. Signature of F	uneral Service	Licensee	feeder	~			ss of Facility	apel	and (ream	ntion rvla	Ser nd 2	yiçes 1234		
an		shock, or heart failure. List only one cause on each line. Intermediate Cause (Final disease or condition) Atherosclerotic (feart Description) 3													Approximate Interval Betwe Onset and Dea	en ath	
cal ier		resulting in death)		Due to	:	1/04	, ,	100	950				- year				
	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.															
	Examiner	that initiated event resulting in death)	r injury s Last	c	(or as a cons	equence of):	:										
	dical			d													
	Medi	IF FEMALE:															
	Physician/Me	23b. Was deceder in the past 12 1 Yes 2, 9 Unknown	2 months? ☑No	23c. If yes, ou 1 \square Live 4 \square Preg 9 \square Unk	birth 2□F gnant at time	of pregnancy 2 ☐ Fetal death 3 ☐ Ectopic pregnancy time of death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year			ar	
	S P	Part II. Other signi	ificant conditi	ons contributing to d	~	, -		cause giv	en in Part I.			,			e cause of dea		
	ted	Curoni	c 09	Structi	re Pu	(mone	ary	11050	456	_	1 🖼	Yes 2[□ No 3	Prob	ably 4 ☐ Uni	known	
	Completed by	Htvi	al F	ribrilla	tion						24a. Was auto perfo 1 □ Yes	psy ormed?/	pri de	ere autorior to coreath?	osy findings ava npletion of cau: 2 □No	ailable se of	
	Be	25. Was case refe examiner?		Hospital:		·		Oth	26. Place of	of Death (
	<u>د</u>	1 ☐ Yes 2 ☐ 27. Manurer of Dea		28a. Date	•	ER/Outpa	atient 3 🗆 [4 LI Nurs		5 Res			(-,,	/)		
	ation	1 ☑ Natural 2 ☐ Accident	5 ☐ Pendir investi	ng (Moi	nth, Day, Year) Inju		28c. Injur Wor 1 □	ḱ?¯` Yes 2∐No		a. 00001100	now injui	y coodino	•			
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rut City or Town, State)										r or Rura	l Route Numbe	r,					
	Medical Certification: To	29a. Certifier (Check only one)	1 Certifyi 2 Medical	ng Physician: To the Examiner: On the and mai	e best of my l basis of exam oner stated.	knowledge, of ination and/o	death occurre or investigation	ed at the ti	me, date and opinion, death	place, an occurred	d due to the at the time	cause(s , date and) and mar d place, ar	iner as si	tated. the cause(s)	_	
	Ĭ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 13, 2009															
		Alexa	ander		ien h	10	PO 0	Box 1	19099	, To	wson,	MO	21	284	/		
Sta istra		31. Date filed (Mor	nth, Day, Year)	3 2009	Registrar's Sig	gnature	park	S		*							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Charlotte Ruth Burmeister Ċ Wember /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death gres MUSPITCH Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7/28/1919 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Days Hours Min Country) PA 186-24-2657 90 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show If them 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, its modical Extraction must be notified at MD Catonsville Baltimore Director 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6348 Frederick Rd. 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No WW I I If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health Care is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental Edward L. Burmeister Grace Allebach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6115 Bellona Ave. Baltimore, MD 21212 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum Niece Charlotte F. Gerczak 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Nov. 13, Beltsville, MD Chesapeake Crem. 4 Donation 5 Dother (Specify) 2009 22. Name and Address of FaciliCAFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licenses Kelbe 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Physician day /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of physician and s the burial-trans Burmeister > Charlotte Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate he funeral director, page 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

200

29b. Signature and title of certifier

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 9,2009 November Samuel T. Dyson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Maryland Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Hours APril 18,1923 Wash.,DC 579-22-2362 86 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show traumatic event, the Medical Exprimer must be notified at 1X Yes 2 ☐ No Director Suitland MD Prince Georges 10q. Citizen of What Country? 10e, Street and Number ō 72 hours after death with USA 20746 23a 1811 Porter Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items ? 12. Was Decedent Ever in U.S. Black, White, etc. Tiggres 2□No 1943− If Yes, Give Year or Dates: 1946 1 Never Married 2 Married õ 1 ☐ Yes 2 🕱 No Specify Specify: Black þ 3 Widowed 4 Divorced 1946 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Meat Cutter 10th marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f ment of Health and Mental I int: If item 27 is marked of Green Maggie William Dyson 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanette J. Dyson/WIfe Suitland, MD 20746 20b. Place of Disposition (Name of Mary Practice and Vertical State)
Mary Practice and Vertical State (Name of Cemetery) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or c 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/09 Cheltenham, MD 22. Name and Address of FacilityAustin Royster Funeral Home Signature of Funeral Service Licenses M00996 3821 14th Street, NW, Washington, DC20011 Part 1. Ehrer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Immediat Cause (Final months **Physician** a Metastatic Adenocarcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner months Liver Metastases Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last weeks be executed Renal Failure physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) □Yes 2□No the 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Ascites, Anasarca, Bilateral Pleural 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Effusions 24a. Was an cate has by page 2 s autopsy performed certificate 1 ☐ Yes 2 🗷 No 2 **N**io 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 1 Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. law requires that the death certificate P.O. Division of Vital Records,

3altimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a, Certifier

(Check only

panich, R8M MD D 0065485

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1500 Forest Glen Road, SIlver SPring, MD 20910 MD Supanich, Barbara 32.

State Registrar

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 November 6. Gail Oliver Debaugh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2505 Westchester Avenue Ellicott City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 20, 1953 9. Birthplace (State or Foreign Country) District 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🗓 F 56 Yrs Columbia 577-76-6038 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🔀 No Director <u>Maryland</u> Baltimore Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 USA 2505 Westchester Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is 1 and 2 should be filed within of Health and Mental Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivian Estep P <u>Harry W. Oliver</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2505 Westchester_Avenue Ellicott City, MD 21043 Henry Debaugh, Husband permit. Pages 1 s
Department of He
Important: If Item
any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/11/09 New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Service in nsee 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Year 4 🔲 Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown 3 Probably 1 □ Yes 2 □ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: I within 24 hours after death.
To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only, one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 2 Ne one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

151

State Registrar 31. Date filed (Month, Day, Year)

HOUR

32 Registrar's Signature

30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)

7141 Security Blvd. Baltimore, MD 21244

OM

usan Enko	State of Maryland / [1-For State Registrar	Department of Certificate of			. No. 200	9 3642					
Physician/	Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death 1746 hrs					
Medical Examine		Enko	Don't Tour land to the set Don't	November 1	11, 2009 4c. County of Deatl						
	Facility Name (if not institution, give street and number) 6737 5th Avenue	4	 b. City, Town, or Location of Dea Dundalk 	unty							
Function		In yrs. last birthday)	If Under 1 Year If Under 24H	Irs. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or					
Funeral Director	218-82-0717 1 M 2XF	48 Yrs.		July 2	Forei	on ountry) Maryland					
	Usual Residence of Decedent	40 113.		July 2	1,1501	raryiana					
any		c. City, Town or Location	on			10d. Inside City Limits					
b wo wa	Maryland Baltimore	Dunda]	lk			1 Yes 2 X No					
the Maryland or 28a-f show any iffied at once. Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	ntry?					
Sa or Dir	6737 5th Avenue		21222		USA						
0036 within 72 hours after death with the Maryland siene. The than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once ompleted by Funeral Director	11. Mantal Status 12. Was Decedent Ev		s Decedent of Hispanic Origin? (14. Race - Amer White, etc.	ican Indian, Black,					
	1 Never Married 2 X Married 1 Yes 2 X	No			Sanaifu T.						
s afte	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete)		Yes 2 X No specify: 's Usual Occupation (Give kind o	of work done	Specify: Wh 16b. Kind of Business	ite					
5-0036 ed within 72 hour ygiene. other than "natt the Medical Exat Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during me	ost of working life. DO NOT use r								
D36 thin 7 re. than edica	12 years	Cas	shier		Convenienc	e Store					
다 출발 플레 O	17. Father's Name (First, Middle, Last)			me (First, Middle, M							
121 I be fil ental I arked vent,	Edward Laubach	1.2	Address (Street and Number of	es Cappor		- Zin Code)					
D 21 should and Me I is ma atic co	19a. Informant's Name/Relationship (Type, Print) Frank Enko Husband	yland 212	I								
nore, MD 2121 gges I and 2 should be fit nt of Health and Mental I i: If Item 27 is marked other fraumatic event, To Be	20a. Method of Disposition		<u> </u>	Date vember	20c. Location - City o						
Baltimore, permit Pages I a Department of He Important: If ite	1 X Burial 2 Cremation 3 Removal from State	crematory or oth		vember 6,2009	Dundalk,M	arvland					
Baltimo permit Page: Department o Important:	4 Donation 5 Other Specify: 21_Signature of Funeral Service Licensee		1	· .							
Ba perm Depa Impo injur	Chatherns Councilles		ame and Address of Facility Onnelly Funeral 10 Sollers Poi	Home Of I	Dundalk,P. Dundalk,Ma	A. ryland 21222					
Physician	23a. Part I. Enter the discusse, or complications that cause in failure. List only one cause on each line.	e death. Do not enter th	ne mode of dying, such as cardia	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and					
Medical	Immediate Cause (Final disease aSeizure disorder										
kaminer	or condition resulting in death) Due to (or as a consequence)										
-	Sequentially list conditions, if any, leading to immediate b	uence of):				 					
i i	cause. Enter Underlying Cause (Disease or injury that initiated										
red RAMine	events resulting in death) Last Due to (or as a consequence of the con	uence of):									
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50, te be execu ysician and : burial - tra	if FEMALE: 23c. If yes, outcome		898 12/29/09 T	<u>l'</u>	23d. Date of delive						
Box 6876(e. death certificate the attending phy- ed for use as the b nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tal death 3 Ectopic pre	gnancy	Month	Day Year					
ath ce	1 Yes 2 ✓ No 9 Unknown 9 Unknown	me of death 5 Ott	her (Specify)		1						
the death certificat the death certificat the death certificate by the attending phyched for use as the Physician/M	Part II. Other significant conditions contributing to death b	out not resulting in the u	inderlying cause given in Part I.	23e. Did tol	pacco use contribute t	the cause of death?					
ires that the signed by I be detach				1 Yes	2 No 3 Pr	obably 4 Unknown					
Records, F The law requires ficate has been sign page 2 should be Completed				24a. Was a		utopsy findings available					
COr law r has b s 2 she				autops perform	med? death?						
tal Rection: The certificate ector, page			26.Place of Death (Che	1 Yes 2	2 No 1 🗸	/es 2 No					
Vital Rechysician: The this certificate all director, page	examiner? Hospital: 1 Innation	2 ER/Outpatient	Other:		Residence 6 🗸 Oth	er: Scene					
on of Vital Records, P.O. Box 6876 anding Physician: The law requires that the death certificate th. 1. After this certificate has been signed by the attending physe funeral director, page 2 should be detached for use as the ion: To Be Completed by Physician/M	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Yea	28b. Time of I	njury 28c. Injury at Work?	28d. Describe h	ow injury occurred						
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visi or Att fter de Direct in by 1	24a. Was an autopsy performed? The part of the part o										
Div Hospital or 24 hours afte Funeral Dis tely filled in	4 Homicide determined (Specify)										
9 >	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exami	knowledge, death occur	red at the time, date and place,	and due to the cause ed at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)					
Division To the Hospital or Atter within 24 hours after dea To the Funeral Directo completely filled in by to	and manner stated	11	29c. License number		29d. Date signed (M						
_ 2	() () () () () () () () ()	1 mosv	O.C.M.E.		November 12,						
	Marie and address of some who are will all a sure of the	ath (Item 23a)			<u> </u>						
0	30. Name and address of person who completed cause of deal Victor Weedn MD JD Assistant Medical E		Penn Street, Baltimore, N	ND 21201							
State		Signature									
Registra	4 4 4 4 6 6 6 7 1 1 1	park									

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				For State	State of Marylan		•			al Hyg	giene	000	36430
				Registrar 1. Decedent's Name (First, Middle, L	4)		Certificate of	Deati				2009	
		Physici /Media		Alice B. Fraczko						ate of Dear	tn Day	Zoo1	3. Time of Death U: Z2 PM
	***************************************	Examir		4a. Facility Name (If not institution, g	ive street and number) RIVERSIDE		4b. City, Town, o	r Location	n of Death		4c. C	County of Death	l
		Funeral	7	5. Social Security Number 6.	Sex 7. Age (In yrs. I	ast birth	day) If Under 1 Year		er 24 Hrs. 8. Da	ate of Birth) Vaari	9. Birthpi	ace (State or Foreign try)
		Director		150-12-7609	1□M 2 ⊠ F 84	Yt	rs. Months Days	Hours	Min. (N	ate of Birth fonth, Day V • 01 ,	1925	Naple	es,Italy
		and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	. Town o	or Location					10	Od. Inside City Limits
		Maryla f sho	P	,			t Hill						1 □Yes 2 No
		the 1	Director	10e. Street and Number	a country 1	0100	10f. Zip Code			1	0g. Citize	en of What Count	ry?
		h with	al D	102 Bower Lane				2105	50		Unit	ed State	3 5
		ems :	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S.	13. Was Decedent of H	lispanic C an. Mexic	Origin? (Specify Y	es or No-	14	4. Race - America Black, White, e	
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evarring must be rectified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced			1 □Yes 2 No	Specif		, 6.6.,	5		nite
	5-0	72 ho	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. D	Decedent's Usual Occup Give kind of work done of ife. DO NOT use retired	ation during mo	ost of working		16b. Kind	d of Business/Ind	ustry
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	d 2	Hygie Hygie Ither i	ပ္တို	08 17. Father's Name (First, Middle, Las	11/A		Seamstres		her's Name (Firs	t, Middle, f		Barbizor urname)	1 N.Y.
	lan	ental ental ked o	To Be	Harry Zengro	•			Mark	ha Biano	hett	i	•	
	ary	shou and M s mar umat	-	19a. Informant's Name/Relationship	(Type. Print)	19b. N	Mailing Address (Street					Town, State, Zip	Code)
	Σ	and 2 ealth an 27 is		Mrs. Barbara M. I	Paul (Daughter)	1	114 Gypsy I	ane			on,M	aryland	21286
	ore	Jes 1 at 1 of He If item		20a. Method of Disposition 1 → Burial 2 → Cremation 3	Removal from State	lace of D emetery,	Disposition (Name of crematory or other place	ce)	Date Nov. 10	5,	20c. Loca	ation - City or Tov	wn, State
	ţ	t. Pag tment tant:		4 ☐ Donation 5 ☐ Other (Spec	ity) Gard	dens	of Faith (2009		Ross	ville, N	Maryland
	Bai	permi Depar Impor any Ir once.		21. Signature of Funeral Service Lice	J. gar, L	2	22. Name and Addre Peaceful 7 2325 York	lter	natives			Crematic aryland	on Ctr.P.A.
				23a. Part / Enter the disease, or con shook, or heart failure. List onl	mplications that caused the death y one cause on each line.	. Do no	t enter the mode of dyir	ng, such a					Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition resulting in death)	a. cardi	0-1	1 pmy	arc	Tug				Onset and Death
	Ť	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of)							
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	Ö.	The law requires that the death certil ate has been signed by the attending bage 2 should be detached for use a	by Physician/Me	in the past 12 months? 1 ☐Yes 2 ☑No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	У				Month	Day Year
	P.O.	w requires that the de been signed by the should be detached	Phy	9 Unknown		ta: : at		i- D		20 Did tol	hanna un	n contribute to th	e cause of death?
-	Ġ,	ires the signer of the d	þ	Part II. Other significant conditions	monarcy Fibro		ne underlying cause give	en in Fan			- 1		ably 4 Unknown
名	ör	requ been should	eted		10010	<u> </u>					- (
FRACZ KOWSK	Rec	slcian: The law certificate has birector, page 2 s	Completed							4a. Was a autops perforr	sv I	prior to con death?	sy findings available apletion of cause of
71	ta	ifficate or, pa		25. Was case referred to medical				26 Plan	ce of Death (Che	perform □Yes 2		1 🗆 Yes	2 □ No
5	<u> </u>	yslcia is cer direct	o Be	examiner? 1 ☐ Yes 2 █ No	Hospital:	ER/Outp	atient 3 DOA Oth		Nursing Home 5			Other (Specify	·)
18	0	ig Ph fter th neral	T:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	90.00	28b. Tin Inju	ne of 28c. Injur			escribe ho			
	sioi	eath, or: Ai	atic	2 Accident investigation	on		M 1 🗆	Yes 2[□No				
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AL		To the Hospital or Attending Physician: The I within 24 hours after death, To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C		Physician: To the best of my know miner: On the basis of examinat and manner stated.								
		To the within To the comple	Me	29b. Signature and title of certifier	4.		29c. Licens	e number		2	9d. Date	signed (Month, L	Day, Year)
4				Ky (1)	Men mo		D2	79	75		11/1	2/09	
		30		30. Name and address of person who	o completed cause of death (Item	23a) (Ty	pe, Print) Mac No	27/	ld hal	Ain	M	7. 211/16	,
		Sta	te	31. Date filed (Month, Day, Year)	32. Regietrar's Signati	ure	· vicev	7 11 9	VI / U/	1111	1-10	0 11019	
		Registra	ar	NOV 13:	2009 Jenna	1	peres						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HIS HER Nohn 11.15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Genesis Elder Care . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Hours M 2 D F 220-14-3294 83 **Director** MD Usual Residence of Decedent show 10b. County . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. It ath: If item 27 is marked other than "natural", or items 23a or 28a-f sho land: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21244 9105 Old Court Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service 9th grade Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Fisher Nettie Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3457 Cottage Ave, Baltimore, Md 21215 Jessie Fisher-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) On-Site 11/12/09 Baltimore, 21. Signature of Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore, Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ COM Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 4 Pregnant at time of death g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Thymana Mille D47683 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) θ Ray Mory Miller Rentestow. MD 21136 25 Main Sweet 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36432 Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 1:43AM **Physician** 08 2009 4a. Facility Name (If not institution, give street and number) Lder /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5. Sociel Security Number enter AUMA Birthplace (State or Foreign Country) If Und 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. Months Hours 1 ☐ M 2 💢 F 80 07 16 Director 249-46-3458 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State items 23a or 28a-f show 1 XYes 2 ☐ No Baltimore Director NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number U.S.A. 21215 3331 Belle Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ¾ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene. 1 ☐ Never Married 2 ☐ Married ò 1 ☐Yes 2 🛛 No Specify: Black 21215-0036 Specify: dical Exar \$ 3 Widowed 4 □ Dîvorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4or 5+) Elementary/Secondary (0-12) Home Housewife 12th grade 7 Is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Elma Wright Alphonso D. Ferrette ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 8534 Stevenswood Road, Baltimore, Md21244 19a. Informant's Name/Relationship (Type. Print) Dazzell Mosley-Son Health Jem 27 other 20c. Location - City or Town, State t: If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or ott
once. ₩₩Burial 2 Cremation 3 Removal from State Owings Mills, Md Garrison Forest Vet 11/8/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West Signatu of fluneral Service License 4300 Wabash Ave, Baltimore, 21215 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disea e or condition ting in death) **Physician** Iraumatic /Medical SOUTH AND THE OTHER PERSONS TO LEAVE BELLEVILLE Due to (or as a consequence of): **Examiner** hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3

Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No Window death. 2 Accident 11-09-2009 09:45 FLOOR neral Director: / trom. 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Seble Rin (t 3 ☐ Suîcide determined after 4 Homicide 21133 mD Home Bolt more 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hor To the Fune completely fi Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signaty and title of certifier ပ FELLO W e and address of person who completed cause of death (Item 23a) (Type, Print) RAHUL NAND Baltimore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State frank.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 6:00 Physician/ Fleet, Jr 2009 Jerome Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N. Robinson Street Balto If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 - F Months Days Hours Min. Country) MD Director 216-84-8174 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Locetion within 72 hours after death with the Maryland Director MD n/a Baltimore 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 408 N. Robinson Street 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes. Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+)n/a Elementary/Seconday (0-12) Disabled Disabled 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ LeGrant Crapper permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. traumatic Jerome Fleet, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 N.Robinson Street LeGrant Branch-Mother Balto, MD 21224 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State oaklawn Cemetery 11-14-2009 1X Burial 2 Cremation 3 Removal from State Balto Co, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H wa 1101 North Avenue MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ 10 RRHOSI disease or condition resulting in death) Medical Due to (or as a consequence of): 4 months **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Vear Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the a 1 ☐ Yes 2 L g ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? r this certificate haral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\begin{picture}(\text{Nesidence} \) 6 \(\sum \) Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 ☐ Yes 2 ☐ No Matural Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 124 hours after death e Funeral Director: upleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the To the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DO060489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite K FrANKLIN. 9940 Dowen

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) B Month, **Physician** 2009 /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NI Manor Nursing Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Pri 1 28) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Months 218-46-8176 1 □ M 2 □ F Maryland Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified once. Director ITIMOU 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2123 Marbourne 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 Your Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ NO Specify: Black altimore, Maryland 21215-0036 Specify: ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shier per mar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I leer lax 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aue , MD 21229 Martingale altimore 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Premation 3 Removal from State altimae, 5 Other (Specify, vematoru 4 □ Donation permit. 21. Signature of Funeral Service Licen salt. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONTRACTOR **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it immediates cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ☐₩nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 rector, page perform 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral dir After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 ⊟ Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 027394 09 11/11/ and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month,

Day,

900

RICHARDSON

M

32. Registrar's Signature

CATON AVENUE

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov Physician/ 2009 7:15a Fisher Robert Spence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Queen Anne Centreville Hospice of Queen Anne County Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Massachusetts 7. Age (In yrs. last birthday) **Funeral** Days July 22, 1941 1 🕅 M 2 🗆 F 046-32-2080 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Royal Oak Maryland Talbot 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21662 5560 Heron Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 🛭 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) iene. r than ' College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with n and Mental Hygien 7 is marked other th Sales Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Jane Spence David Alexander Fisher 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd G. Fisher/Son 18 Hickory Road, Sudbury, Massachusetts, 01776 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 13, permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 200922. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee ouce. Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Soph Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading 15 mm of the cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of Exami requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has t autopsy perform Hospital or Attending Physician: The 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Mouse 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signatu and title of certif 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8221

32. Registrar's Signature

avid Smith, MD

31. Date filed (Month, Day, Year)

TROIDTIVE SUITE 301, Easton, MD

9-08712	Please Type or Print in Black Inc		
Glen Howard Footm	otate of Maryland / Dopar	tment of Health and Mental Hy ificate of Death	2000 2012
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	incate or Death	Reg. No. 2. Date of Death 3. Time of Death
Medical Examiner	Glen Footman		Month Day Year November 9, 2009 1215 hrs
	4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	st birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director	007-66-0495 1 _X M 2 _F 52 Usual Residence of Decedent	Yrs.	10/03/1957 Maine
any		Town or Location	10d. Inside City Limits
r. 1 🖹	Maryland N/A	Baltimore	1 XYes 2 No
the Maryland a or 28a-f sho utified at once	10e. Street and Number	10f. Zip Code	10g, Citizen of What Country?
th the sa or notific	6936 Donachie Road, Apt. D	21239	United States
er death with t	11. Marital Status 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	
fired or Fu	1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify: White
ours aft	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of viduring most of working life. DO NOT use reti	/ork done 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)		
5-0036 led within 7 Hygiene. I other than the Medica	17. Father's Name (First, Middle, Last)	Counselor 18 Mother's Name	Addiction Treatment (First, Middle, Malden Sumame)
215 be file mtal Hy rked o ent, th	Harold Rodney Footman	Joyce	Marie Tartiff
MD 2121 d 2 should be ff th and Mental I n 27 is marked tumatic event, To Be	19a. Informant's Name/Relationship (Type, Print)	, i	Rural Route Number, City or Town, State, Zip Code)
MC slath are the 27 raums	Alejandro Chavarria/ Partner 20a. Method of Disposition 20b. Pi	11843 Braesview Drive	#2205, San Antonio, Texas 78213 Date 20c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		rematory or other place)	ber 10,
it. Pagirtment	4 Donation 5 Other Specify: Metro 21. Signature of Funeral Service Licensee 4 and 1 ston		009 Baltimore, Maryland ation Society of Maryland, Inc.
Ba Perm Depa Impo	Au l RA		Ltimore, Maryland 21228
Physician	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac of	r respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical vaminer	Immediate Cause (Final disease a. Complications	of gunshot wound to th	
	or condition resulting in death) Due to (or as a consequence of)		
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)	:	
ted I unsit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last under the control of the contr	:	
ecuted and transit	d		
	Xunpended 23a,27,2	28a-f,perME, g899 1/6/1	
876(tificate ng phy as the b	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregn 1 Live birth		23d. Date of delivery Incy Month Day Year
). Box 68760, the death certificate be early by the artending physicial cheef for use as the burial Physician/Media	past 12 months? 4 Pregnant at time of dea	2	
Bo, the att shed for Physics	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
P. C	Tark II. Other significant conditions	sailing in the dilucitying cause given in raici.	1 Yes 2 No 3 Probably 4 Unknown
Records, 1 The law requires ficate has been sig page 2 should be Completed			24a. Was an 24b. Were autopsy findings available
Recol The law icate has l page 2 st			autopsy prior to completion of cause of death? 1 Ves 2 No 1 Ves 2 No
tal Rections. The certificate ector, page	25. Was case referred to medical	26.Place of Death (Check	
f Vital I Physician: er this certifi ral director, To Be C	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nursin	ng Home 5 Residence 6 Other:
n of V ding Ph After th funeral	1 Notural (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred subject shot
ivision or Attencath Director: J in by the	2 Accident Investigation Fd 9/22/09	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending nous after death the relief in by the fune Certification:	Suicide Could not be	ther	or Town, State) 600 Blk. N. Howard St. Baltimore, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the	29a. Certifier 1 Certifying Physician: To the best of my knowledg	e, death occurred at the time, date and place, and	due to the cause(s) and manner as stated.
To the Howithin 24 h	one) 2 Medical Examiner:On the basis of examination an and manner stated.		
Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	IN C - IM	O.C.M.E.	November 10, 2009
Ø V	30. Name and address of person who same eted cause of death (Item Russell Alexander MD. Assistant Medical Exam		D 21201
State	31. Date filed (Month, Day, Year) 32. Kegistrar's Signatur		
Registrar	NOV 1 3 2009 Januar A	. Sarle	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 17:40PM Month ardnar **Physician** 000 luclambar 12009 /Medical 4a. Facility Name If not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 30, 1934 5. Social Security Number Birthplace (State or Foreign
Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 - M 2 X F 75 Maryland 213-32-0500 **Director** Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. 10a. State 10h County items 23a or 28a-f show 1 Yes 2 X No Director must be notified Maryland Howard Columbia 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code 6310 Tamar Drive 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: <u>Ş</u> White 3 X Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Henry Mallonee Yolanda Strappelli ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a tem 27 i Alison Gardner (Daughter) 6310 Tamar Drive Columbia, Maryland 21045 or other If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or otl 1X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 11-12-2009 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service Licenses Inc. Columbia, Maryland 21045 se, or complications that caused the List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. U fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** romusia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Cectopic pregnancy Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 / No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) à determined 4 Homicide the Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 MD tei 600 North Wolfe St, Baltimore, MD, 21287 Sarbata Day, Year) egistrar's Signature 31. Date filed (Month, State

DHMH 17 Rev 1/200

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 30, 2009 2:30 PM M James Glover October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frankford Nursing & Rehab Baltimore 8. Date of Birth (Month, Day, Apr 16, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 82 Director 247-32-7707 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
The show shall hygiene and the than "natural", or Items 23a or 28a-f show ant; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 Is a wind the should the should be a larger and the should be a large 10h County 10c. City, Town or Location 10a. State 10d. Inside City Limits X Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 3328 McElderry Street Funeral 12. Was Decedent Ever in U.S.UNK
Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No black. Specify þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disabled unk none unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trauonce. 21206 5009 Frankford Avenue Baltimore, MD Frankford Nursing & Rehab 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify) in state Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, of complications that caused the death. Shock, of heart failure. List only one cause on each line.

Immediate Cau (Final disease or condition resulting in death)

a.

Battimore, FID 21201

Do not enter the mode of dying, such as cardiac or respiratory arrest, and a cardiac o Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed burial-trar Due to (or as a consequence of). Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy The certificate 2 No 1 □ Yes 2 No 1 🗌 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1∐ Yes 21/2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death ne Hospital or Attending Pin 24 hours after death. 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) To the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nom Woods Road. 31. Date filed (Month, Day, State 1 3 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 2009 1220 pM November John Wavne Glacken /Medical 4b City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ST. Agnes HospitAl Bultimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Jumber 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days 1 ₹M 2 ☐ F 214-62-1991 Director 54 Apr 14 1955 Maryland Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, I'm McJical Evaminer must be notified at 1 □Yes 2 No Director MD Baltimore Baltimore Highlands 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 **USA** 2690 Virginia Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1∐Yes 2XX No Specify: Specify: ð White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Glacken Esther Moyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ellen Glacken - Wife 2690 Virginia Ave., Baltimore, MD 21227 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-11-2009 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 21. Signature of Funeral Service Licensee 2719 Hammonds Fry Rd., Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final atherosaldatic coldi **Physician** 2 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the announcement at serial of our Examine day, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy e Hospital or Attending Physician: The 124 hours after death.
e Funeral Director: After this certificate heletely filled in by the funeral director, page perform 2 Z No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 🗌 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a, Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 0003306 Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 4 unas tospital 120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Stephen Hyman State of Maryland / Department of Health and Mental Hygiene 2009 36440 Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ November 8, 2009 1208 hrs Medical Examiner Stephen 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Good Samaritan Hospital N/A 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country) Months Days Min Hours Director 12/10/1955 218-68-6892 1 X M 2 53 Yrs Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No 28a-f shov Baltimore Baltimore MD death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code U.S.A. 21234 3306 Northway Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 2 X No Yes permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", oi injury or other traumatic event, the Medical Examiner m Specify: White Yes, Give Yeer 4 X Divorced 1 Yes 2 X No specify: Widowed <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Business Owner Bar 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bellestri æ Elizabeth F. Hyman Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3306 Northway Drive, Baltimore, MD 21234 Elizabeth Hyman, Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 11/12/09 Towson, Marvland Svc. Corp. Donation 5 Other Specify: Hillton Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road, Baltimore, MD 21214 soons 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED has been signed by the attending physician 2 should be detached for use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Alcohol abuse, lymph edema of lower extremities Completed Records. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate ✓ Yes 2 No 2 No 1 V Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Division of Vital examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 Other this Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes No After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: n 24 hours after death.

Funeral Director: A letely filled in by the fur 1 V Natural Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the 1 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 9, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 11 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per dec 9897 11 13 09 and Mental Hygiene 2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:20 A^M James С. Hart November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8384 Elvaton Road Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Months Days Country 230-36-9434 11 1932 Director July Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Hygiene. other than "natural" or items 23a or 28a-f shov ent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Millersville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8384 Elvaton Road 21108 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Septic Service 4 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther F. ပ Hart Sarah F. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy C. Hart (spouse) 8384 Elvaton Road, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2009 Glen Haven Cemetery Glen Burnie, Maryland 21. Signature Funeral/Service Unsee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Fasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Corobro **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ₹ Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 1 ☐ Yes 2F1 No Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 50 46 81 C 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anil Chopra, M.D. 7575 Ritchie Highway, Glen Burnie, MD 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland / Dep	artment of Health and Mental Hygiene rtificate of Death Reg. No 2009 36442					
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Rock 4a. Facility Name (If not institution, give street and number) Sinai Hospital	2. Date of Death Day Year 3. Time of Death Month Day Year 11 09 2009 11:31a. Month Baltimore 4c. County of Death					
	Funeral Director		5. Social Security Number 237-46-6343 Osual Residence of Decedent 6. Sex Amage of the Se	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) NC					
	h the Maryland rr 28a-f show unciffied at	Director	10a. State 10b. County 10c. City, Town or Life MD NA Balt 10e. Street and Number 10e. Street and Number	imore 10d. Inside City Limits ince ½ Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country?					
15-0036	d within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Medical Extra of ser must be recitived at	by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education 16a. Dece	21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or NotYes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I □ Yes X□ No Specify: Specify: Black dent's Usual Occupation 16b. Kind of Business/Industry					
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Maryland	d 2 should be th and Mental 27 is marked o traumatic eve	ToB		Minnie ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
ore,	permit. Pages 1 and Department of Health important: if item 27 any injury or other to Once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Keyworth Ave, Baltimore, Md 21215 sition (Name of natory or other place) te 11/17/2009 Baltimore, Md chame and Address of Facility rch F/H West OO Wabash Ave, Baltimore, Md 21215					
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that cause the death. Do not en shork, or hear if ilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):						
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C. Box a	ding Physician: The law requires that the death certificate. h. Arer this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	Physician/Medi		Ectopic pregnancy 23d. Date of delivery Month Day Year					
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5	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Cert	4 ☐ Homicide determined building, etc. '(Specify) 29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and due to the cause(s) and manner as stated. vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
)	To the To the Company of the Company	M	29b. Signature and title of certifier 30. Name and address or berson who completed cause of death (Item 23a) (Type,	29c. License number 29d. Date signed (Month, Day, Year) NUII 11. 200 9 Print) Reluedere am Berkmene.					
	Sta Registr	ite rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Reludere am Bettimen.					
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		For State Registrar	State of Ma	aryland /	Depa <i>Cer</i>	rtment of H	ealth ar Death	nd Mental	Hygier Reg. N	1e 200	9 36443
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Funeral Director	GI	Johns Hopkins Bo	Myrew Medi	tal (en e (In yrs. last b 39	irthday) Yrs.	Ball If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of (Mont	of Birth h, Day, Yea -1920	ar)	RE CITY Birthplace (State or Foreign Country) aryland
nd >	٥٢	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo:		10c. City, Tov	vn or Lo	cation	Balt	imore Co			10d. Inside City Limits 1 Yes 2 X No
with the Marylan 3a or 28a-f show	Funeral Director	10e. Street and Number 4309 Belmar Aven				10f. Zip Code	21206			Citizen of What	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandret must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 30XWildowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 II If Yes, Give Ye ar or Dates:			Vas Decedent of Hi Yes, specify Cubar □Yes 2√2 No	spanic Origin, Mexican, F	n? (Specify Yes of Puerto Rican, etc.)	or No-		American Indian, /hite, etc. White
ed within 72 haygiene.	Completed	15. Decedent's Eigenstand (Specify only highest grades) Elementary/Secondary (0-12) 12 yrs.	ducation ade completed) College (1-4or 5 1 yr.		(Give life. L	lent's Usual Occupa kind of work done d OO NOT use retired, DETVISOT	ation luring most o)	of working		Kind of Busine	
ld be file lental Hy ked oth ic event	To Be (17. Father's Name (First, Middle, Las Sebastian Greise				:		s Name <i>(First, M</i> 1e Lowery	,	en Surname)	
12 shou th and M 7 is mar traumat		19a. Informant's Name/Relationship	(Type. Print)			g Address (Street a	and Number	or Rural Route N	lumber, Cit		
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permit. Pa Departme Important any injury once.		4 Donation 5 Other (Special Service Lice		Most_ >	22 L	Redeemen	s of Facility	Home		•	Maryland
Physician /Medical Examiner	_	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as	one. UMO VI a consequence	o not ent	401 Belai				lu. ZIZ	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the aftending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or Injury that initiated events resulting in death) Last	с	a consequence							
that the death certificated by the aftending photoetached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant In the past 12 months 1 Yes 2 Ook 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	/			23d. Date of Month	f delivery Day Year
iw requires that s been signed t	ρχ	Part II. Other significant conditions		ut not resulting	in the u	nderlying cause give	en in Part I.	23e.		co use contribu	te to the cause of death? Probably 4 Unknown
n: The law ricate has be	Completed							24a.	Was an autopsy performed Yes 2 D	? prio	e autopsy findings available r to completion of cause of th? Yes 2 □ No
ysiciar is certif director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ☐ ER/0	Outpatier	nt 3 □ DOA Othe	ar-	of Death (Check sing Home 5		e 6 ∏Other /	(Specify)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ertification: T	27. Manner of Death 1 Deatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28a. Date of Inju (Month, Da	ry 28b y, Year)	Time of Injury	28c. Injury Work M 1 🗆		28d. Des		njury occurred	Open,y,
pital or At ours after d eral Direct filled in by	ပ	4 ☐ Homicide determined	28e. Place of inj	c. (Specify)		eet, factory, office	no date and	City	or Town, Si	tate)	or Rural Route Number,
the Hos	Medical	(Check only 2 Medical Exa	miner: On the best and manner st	of examination a	ge, deat and/or in	vestigation, in my o	pinion, death	h occurred at the	time, date	and place, and	due to the cause(s)
5 *** 6 00 00 00	2	29b. Signature and title of certifier		-		29c. License	e number 09195	5	1		Month, Day, Year) - 6, 2009
6 V		30. Name and address of person who	completed cause of o	leath (Item 23a				altimor			21224
Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature			,				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		amend #4a Pe	pe or Print in B Fate ^b y Maryar						ble.	
		State Registrar		Cei	rtificate of l	Death		Reg. No. 2	Pnr	361.1.1.
Dhusisis		1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
Physicia /Medica		Charlotte Hu	dlow				Nov 9,	2009	,	10:49 PM
Examine		4a. Facility Name (If year institution, give streets) 5903 Ottowa Streets	eet and number)		4b. City, Town, or Oxon		h	4c. County Pr	ince	George's
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	* -	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	ay, Year)	9. Birthpl Coun	lace (State or Foreign try)
Director		311 30 1020	1 x x x 5 82	Yrs.			Dec 16	, 1926	Wash	nington DC
and and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10	0d. Inside City Limits
Maryl f sho	ō	Maryland Prince	George 0:	on Hi	11					1 □Yes 2√√No
r 28a-f show	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
23a or	<u></u>	5903 Ottawa	Street		207	7.4.5		United	State	26
ms 2	Funeral		Was Decedent Ever in U.S	6. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No		ce - Americ	an Indian,
ours after deat rai", or items : Evanine mu		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX X Year or Dates:			Specify:	to Hican, etc.)		ck, White, e	
ours	d b	3 ☐ Widowed 4 🎇 Divorced	Year or Dates:		1 □ Yes 2 □ No	ореслу.		Specil	, MI	nite
72 h "natu	ete	15. Decedent's Educat (Specify only highest grade of	ion om <i>pleted)</i>	(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of B	lusiness/Inc	lustry
within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		e Dept	2)		Secret	tarv	of Treasure
flied within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Evaminer must be notified at	ပို	17. Father's Name (First, Middle, Last)		Stat	e pept	18. Mother's Na	me (First, Middle	1		01 11 00001
ld be lental ked c	To Be	Julian A. Jo	hnston			Rutl	me (First, Middle 1 P. Van	stone		
shou and N mar umat	-	19a. Informant's Name/Relationship (Type	. Print)	19b. Mailir	ng Address (Street	and Number or F	ural Route Numb	er, City or Town	, State, Zip	Code)
and 2 salth a		Anna Gibson	(Daughter)	8601	Temple H	Hill Roa	ad #35,	Temple I	Hills,	, MD 20748
of He fiter		20a. Method of Disposition	C.	lace of Dispo	sition (Name of matory or other plac	ce)	Date	20c. Location	- City or To	wn, State
Pag ment ant: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		e Crem	atory No	ov 10. 20	009	Clinton	n, MD	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Eva once.		21. Signature of Funeral Service Licensee	M01391	22	2. Name and Addre .lexandria	ss of Facility L	ee Funer Road, C1			
Physician /Medical		23a Fart1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)		yelos	ter the mode of dyin	1 C	c or respiratory a		ی	Approximate Interval Between Onset and Death
Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
icate be executed physician and the burial-transit	Examiner	that initiated events C.								
E 39. 9	=	resulting in death) Last	Due to (or as a consequ	uence of):						
cate t	dica	d.								
death certif e attending d for use as	Physician/Medica	in the past 12 months? 1 □ Yes 2 ☑ No	. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	☐ Ectopic pregnand	ey .			ate of deliver	ery Day Year
that the dene of the detached is	Phy	9 Unknown		utation of the state of		i- D1	220 Did	tahaasa usa sar	stributo to th	ne cause of death?
Se ig es	ed by	Part II. Other significant conditions contr	buting to death but not rest	anng in the a	muenying cause giv	en in Faiti.		Yes 2		pably 4 ☐ Unknown
e law re has be je 2 sho	Completed						24a. Was		. Were auto	psy findings available mpletion of cause of
The l	mo:						perf 1 □ Yes	ormed?	death?	2 No
Iclan: The certificate ector, pag	Be (25. Was case referred to medical examiner?					eath (Check only			
this il dir	မ	1☐ Yes 2☐MO	spital: 1 ☐ Inpatient 2 ☐			4 LI Nursing	Home 5 Res			y)
D 0 0	ation:	27. Manno of Death 1. Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred								
al or Atte s after de i Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	me, farm, str	reet, factory, office			(Street and Num wn, State)	ber or Rura	al Route Number,
	Medical (r: On the best of my kno r: On the basis of examina and manner stated.							
To th Within To th	¥	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
) You !	1			352		11/10	1200	7
11		30. Name and address of person who com Harvey Katzen	pleed cause of death (Item , M.D. 8926	v 23a) (Type, Woodya	erd Road	Suite 10	1, Clint	on, MD	2073	5
Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	tures	D					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aileen Hanifee 2005 12:40 AM November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** Months Days Hours July 20 Director 217-12-9011 85 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f st notified Maryland Harford Aberdeen 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 214 Baltimore Street 21001 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White "natural" Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 years Packer Paper Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic eve John William Pritchett Arentha McClain Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharron Carter Daughter 214 Baltimore Street, Aberdeen, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 14, 2009 Baltimore, Maryland Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 Part 1. Enter the disease of complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hencel Physician/ tailure Acute disease or condition day Medical resulting in death) Due to (or as a consequence of): **Examiner** HyperKalemia day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami AUAP Metabolic acidosis 7/ day Due to (or as a consequence of) resulting in death) Last Physician/Medical day Breest metas teetic Cancer IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 month 1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Unknown o. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P. Completed by page 2 should be COPP Padyet's discare 1 Yes 2 No 3 Probably 4 Unknown maculeur degeneralives 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes 2 No 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital the funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending injury work? 1 Yes 2 No s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical 1 Lecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29c. License number Bangaria, 11/11/2009 DO065641 Kamal 30. Name and address of person who completed cause of death (Item_23a) (Type, Print) HAVRE de GRACE, MB 21078 501 S. UNION AVE MD 31. Date filed (Month, Day, Year Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	partment of leartificate of				09 36446
	Physic /Med		1. Decedent's Name (First, Middle, La.	ewgen		-		2. Date of Dea Month	th Day	Year 3. Time of Death
Sec. 1	Exami	ner	4a. Facility Name (If not institution, give			Baltin	or Location of Deat	n i	4c. County o	
	Funeral Director		5. Social Security Number 6. S 093–38–6468 1 Usual Residence of Decedent	ex 7. Age	e (In yrs. last birthday 61 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day November		Birthplace (State or Foreign Country) New York
	Maryland a-f show	tor	10a. State 10b. County Maryland Howard		10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28a set be noti	al Director	10e. Street and Number 10798 Folkestone Way		WOODS	10f. Zip Code	63	1	0g. Citizen of W	nat Country?
36	J within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Evantinar cust be notified at	by Funeral	11. Marital Status 1 □ Never Married 2003 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 □ No If Yes, Give		. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race	- American Indian, White, etc.
1215-0036	thin 72 hou re. an "natural Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	durina most of wor	king	16b. Kind of Bus	White iness/Industry
Maryland 21	ild be filed within fental Hygiene. 'ked other than " ic event, the Me	Be	17. Father's Name (First, Middle, Last) Norbert Hengen	College (1-4or 5+	Banke	r		ne (First, Middle, M		
Maryi	d 2 shouth and N	2	19a. Informant's Name/Relationship (7		1	ing Address (Street	and Number or Ru		; City or Town, S	tate, Zip Code)
more,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Nife)	20b. Place of Dispo cemetery, cre	Folkestone osition (Name of matory or other place	ce)	ock, Maryl Date	20c. Location - C	ity or Town, State
baltimor	permit. I Departm Importal any inju		21. Signature of Funeral Service Licens		Atlantic C	2. Name and Addre 1tzke Funera 555 Twin Kno			Glen Burr	nie, Maryland
√ F	hysician		23a. P rt1. Enter the d sase, or somp shock, or heart failure. List on Immediate Cause (Final disease or condition	lications that caused the cause on each line	the death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
je i	/Medical Examiner	<u>.</u>	resulting in death)	Diabet	consequence of):	us	The state of the s	Jisas 3		> 540ms
) oo'	ifficate be executed g physician and as the burial-transit	cal Examiner	Sequerition, led to cultivate if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	consequence of):					,
O. DOY 00	rine law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy	/		23d. Date of Month	,
	n signed by	þ	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?
		Completed						24a. Was an autopsy perform	24b. We priced?	re autopsy findings available or to completion of cause of ath?
o le co	certificate	Be	25. Was case referred to medical examiner?	lospital:		Tail	26. Place of Deat]Yes 2□No
5 6	er this	12	1 Yes 2 No F	28a. Date of Injury	2 ER/Outpatier		4 Inursing Ho	me 5 Resider		(Specify)
	sath. or: Afti he fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,)	Year) Injury	Work	?" /es 2 🗆 No	28d. Describe how	v injury occurred	
ital or Att		Certification:	3 Suicide 6 Could not be 4 Homicide determined		/ - At home, farm, stre (Specify)			City or Town,	State)	or Rural Route Number,
the Hoer	thin 24 hor the Fune impletely fi	Medical	one)	sician: To the best of oner: On the basis of each manner state	xamination and/or in	vestigation, in my op	einion, death occur	and due to the ca red at the time, da	use(s) and mann te and place, and	ner as stated. If due to the cause(s)
٩	10		29b. Signature and title of certifier				27739	29	d. Date signed (#	Month, Day, Year)
	Stat		30. Name and address of person who co MKITIL PATEL , UMM 31. Date filed (Month, Day, Year)	mpleted cause of deat 32 Registrar's	ZZ Sout	h Greeve	st. B	Himore M	10 2120	
	Registra	_	200 A D 200		M. 400	1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36447 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Laura Lavice Harrison 2009 November 4:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sykesville Carroll Oakland Manor Assisted Living 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2424 F Days Hours (Month, Day, Year) 07/20/1919 90 Yrs Director VA. 212-07-8292 Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits MD. Carroll Sykesville 1XXYes 2 □ No ۵ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 U.S.A. 2810 Kaywood Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White ¾ Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 is and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Lloyd Woolard Annie Clarke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si
Department of Health ar
Important: If item 27 is Stephen Harrison/Son 6832 Autumn View Drive Sykesville, MD. 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/17/2009 4 Donation 5 Other (Specify) Lorraine Park Cem. Woodlawn, MD. of Funeral Service Licental 21. Sign 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road & Crematory, P.A. Winfield, MD. 21784 Part 1 Enter the disease, or complication shock or heart failure. List only one cau hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Approximate Interval Between Onset and Death andis vascucaz ediat Cause (Final Athens Physician/ di ease o condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nonsequence of Examir The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the g Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: Assit မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu М Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (ly one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09 43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

MUDOUS)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Stella Howell 2000 buern 21.35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death n/a Union Memorial Hospital Balto 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 11-16-1933 Director 214-38-8758 N.C Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No N/A Balto MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3204 Loch Raven Blvd 21218 US 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify 3 XWidowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)n/aElementary/Seconday (0-12) Nancy Hamond 8th grade Caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Annie Pittman 2 Jesse Lucas, 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eddie Howell-Son 255 Meadow Glen San Antonio, 78227 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State King Memorial Pk 11-14-09 Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Avenue Balto, 21202 MD 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Asthmo disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transi[†] that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death Other (specify) Month Day 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed Nellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Records, P.O. Box 68760 Division of Vital completed filled in by the

DHMH 17 Rev 7/2009

State

Medical

4 Homicide

29a. Certifier

(Check only one) 29b. Signature and title of cortifie

determined

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per FH G897 11/17/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Dorothy Himmelheber November 2009 7:15 /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 1306 North Rolling Road Catonsville Baltimore Social Security Numb If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 9, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🛣 F Jan Director 78 <u>Pennsylvania</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo Baltimore Maryland Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 1306 North Rolling Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 🕅 No Specify Š Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It a M once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Austin Smith Mary Shaver ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Barclift, Daughter 1306 North Rolling Road Catonsville, MD 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/12/09 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Box 68760 physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Day 5 Other (specify) P.O. detached 9 Unknown þ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Hospital or Attending Physician: The perform 2 **N**0 Vital 1 □ Yes 2 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 □ Yes 2 □ No 24 hours after death. Funeral Director; A 2 Accident investigation filled in by the ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number of death (Item 23a) (Type, Print) 8011011

State Registrar 31. Date filed (Month, Day,

Year)

32.

egistrar's Signature.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Month SSE 10:00p Nov 9, 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Future Care-Charles Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 N 2 F 250-48-8861 Director Sep 1, 1934 So. Carolina Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow the Medical Exeminer must be notified at 1 ☐Xes 2 ☐ No Maryland n/a Baltimore Director 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Iteme 23a or 301 McMechen Street U.S.A. 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ ¥o If Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **M**o Specify. Specify: Black þ 3 Widowed 4 Drivorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Teacher/Scientist 12 other it of Health and Mental Hyg If Item 27 le marked other or other treumatic event, permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any lijury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ulysses Holmes Sr. Evelyn Rivers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43241 Valiant Drive South Riding, Virginia 20152 Bernard Holmes 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/14/09 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signal in of Eureral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enfer the disease, or complications that caused the death. D not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Proysician /Medical Due to (or as a minsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine or Attending Physician: The law requires that the death certificate be executed burial-transli Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical use as the ettending | for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No cate hes been sly page 2 should t 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform this certificate a No 1 ☐ Yes : After this certification : Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 Mo Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. I Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide filled in To the Hospital Certifying Physiciam To the best of my knowledge, death becomed at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 LIAU 2 31. Date filed (Month, Day, Year) 33 Registrar's Signature. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day C3 Month / (AMILTON H GR 2009

4b. City, Town, or Location of Death

4c. County of Death

Examiner Funeral

Physician

/Medical

For State Registrar

4a. Facility Name (If not institution, give street and number)

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitai or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran been signed by the should be detached within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral dire

Division or Vital Records, P.O. Box 68760,

	LEVINDALE NURSI	NG CENT	ER		BALT:	IMORE			N/A	
	5. Social Security Number 6. 8	Sex 1 □ M 2 2 F	7. Age (In yrs. i 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	8. Date of Bir (Month, Date 12-1	7–1920	9. Bir SOL	thplace (State or Foreign ountry) JTH CAROLINA
	Usual Residence of Decedent									
	10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
lo Be Completed by Funeral Director	MD. N/A		В	ALTIMO	RE					1√Yes 2 No
ě	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	ountry?
a	2434 W. BELVEDE	ERE AVE.			212	15		US	A	
ner	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	S. 13. \	Was Decedent of H	ispanic Origin?	(Specify Yes or No	o- 14. F	Race - Ame	erican Indian,
7	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 📉 No	ì	1 □ Yes 2.XXIo	Specify:	erio riican, etc.,			ie, eic.
5	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates:		100 24260	орсону.		Spe	ecify: BI	LACK
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3	-12-	-0-		IEA	CHER	40.14.11.1.1		SCHOO		SIEM
Re	17. Father's Name (First, Middle, Last	")				18. Mother's I	lame (First, Middle	, Maiden Suri	name)	
2	ELI_HAMILTON						ALSTON			
	19a. Informant's Name/Relationship				ng Address (Street			-		
	READE HAMPLTON		00h D		GLENCRES		Date Date			
1	20a. Method of Disposition 1 ☑Burial 2 ☑cremation 3 ☑	Removal from S	State Z00. P	emetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Locatio	on - City of	Town, State
4	4 □ Donation Other (Speci		HIL	LCREST	MEM. GAI	RDEN 11	-12-2009	ANNAPO	LIS,	MARYLAND
	21. Signature of Funeral Service Lice	TANOK	HAN D.							4. CHAPL, IN
-4	Jaste	U.YA	Mon		27 E. LIN				LLE,	
	23a. Part1 Inter the disease, or come show or heart failure. List only	plications that ca one cause on ea	aused the death ach line.	n. Do not ent	er the mode of dyin	g, such as care	liac or respiratory a	arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease) if condition resulting in death) a. TERMINAL DEBILLITY								Oriset and Death		
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	Cause (Disease or injury that initiated events resulting in death) Last	c								
Û	roduling in death) East	Due to (or as a consequ	uence ot):						
by Physician/Medical Examiner		_d								
Z Z	IF FEMALE:	000 16								
0	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	Ideath 3□	Ectopic pregnancy	,			Date of de Month	elivery Day Year
SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn: 9□Unkno	ant at time of down	eath 5∟	Other (specify)					
E	Part II. Other significant conditions	contributing to de	ath but not resu	ulting in the ur	ndarlying cause giv	en in Part I	23e Did	tobacco use c	ontribute t	to the cause of death?
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completed							24a. Was auto	psy	prior to	utopsy findings available completion of cause of
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2	25. Was case referred to medical examiner? 26. Place of Death (Check only one									
5	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Ir	npatient 2	ER/Outpatien	t 3 DOA Oth	er: 42 Nursin	g Home 5 ☐ Res	idence 6 □	Other (Spe	ecify)
ġ	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Montal	of Injury h, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury oc	curred	
	2 ☐ Accident investigatio	n				Yes 2 ☐ No				
	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	Zoe. Place	of injury - At ho	me, farm, str	eet, factory, office			(Street and Nu	ımber or F	Rural Route Number,
5										
Medical Certification: 10 be	29a. Certifier (Check only one) Certifying Pl	nysician: To the miner: On the ba and mann	asis of examina	wledge, death tion and/or in	n occurred at the tirvestigation, in my c	ne, date and pl pinion, death o	ace, and due to the ccurred at the time	cause(s) and , date and pla	l manner a ce, and du	is stated. ie to the cause(s)
ž Z	29b. Signature and title of certifier	and main			29c. Licens	e number		29d. Date sid	ned (Mon	ith, Day, Year)
	& Jam	PHYS	ICIAN	.	1	00643	5 2	11	104	
					1 100-		GERMATI	uc CTT	1 - 1	7001
	30. Name end address of person who	completed cause	e of death (Item			BEINENE		As		- 1.1 7 . 2 . 4

State

Registrar

31. Date filed (Month, Day, Year)

1 3 2009

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:31 A 2. Date of Death Physician/ Day Month Catherine Lee Iacaruso Novembe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 212-26-1051 1 M 2 XF Months Days Hours Mary Tarid 81 Director Usual Residence of Decedent pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2522 Burridge Road 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ♣No If Yes, Give Maryland 21215-0036 Specify: white 1 Yes 2 X No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Credit Union Elementary/Seconday (0-12) College (1-4 or 5+) Office Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lee Randolph Peddicord Mary Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Iacaruso-spouse 2522 Burridge Road-Baltimore, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel and Cremation-Belair Nov.13,2009 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 LNE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Wecks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Tes 2 No hospiu 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖟 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 28b. Time of 28c. Injury at 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. стрleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58303 November 12 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARVES 6701 Chales ST JONSON MD Ni 31. Date filed (Month, Day, Year) gistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Allen Mark Johnson Movember 3,2009 Year As Facility Name (in not institution, give sirerel and number) As Four Months As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution, give sirerel and number) As Facility Name (in not institution) As Fac	Time of Death 2214 hrs
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102. State 10b. County 10c. City, Town or Location 10d. Ci	ce (State or ') MD
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Physician Medical Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of)	21202
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to	pproximate Interval etween Onset and
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Worth Past 12 months? 1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the case of the cas	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the case of the cas	
24a. Was an autopsy performed? 1 V Yes 2 No 1 V Yes 25. Was case referred to medical 26. Place of Death (Check only one)	
Series Se	y findings available
= 3 25. Was case referred to medical 26. Place of Death (Check only one)	2 No
25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other, Nursing Home 5 Residence 6 Other.	
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25. Was case referred to medical examiner? 1	
4 E 4 E One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau	oute Number, City
29c. License number 29d. Date signed (Month, D	
November 4, 2009	use(s)
30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	use(s)
State 31. Date file 100 1, 193 2009 32. Registrar's Signature	use(s)

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ruth Kohl 10:28 AM November 09 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours 1 □ M 2 🖫 F 82 March 21, 1927 Maryland 220-22-1214 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Harford Baldwin 1 ☐ Yes 2 TNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5435 Lynch Lane 210 13 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banking Bank Teller 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Kohl Marie Debelack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Kohl/ Brother 5435 Lynch Lane, Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/09 Parkville, MD Park 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Parkville, MD 21234 23a Part . Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death 2XC Immediate Cause (Final Year disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery t pregnant 3 🗆 Ectopic pregnancy months? Month Day Year 5 ☐ Other (specify) ficant conditions contributing to death but not resulting in the underlying cause given in Part I

Physician /Medical Examiner

Physician

Examiner

10a. State

MD

Director

Funeral

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Completed

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Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be retified at

is marked other

should be fi and Mental

Pages 1 and 2 s ment of Health ar

permit. Pages 1 and Department of Healt Important: If item 2 any injury or other: once.

filed within 72 hours after death with the Maryland

/Medical

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Physician/Medical

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Certification: To

Medical

1	IF FEMALE:
1	23b. Was deceden
1	in the past 12
ı	1 □ Yes 🎉
	9 ☐ Unknown
1	Part II Other signif

1 ☐ Yes

1 Natural

Manner of Death

23e. Did tobacco	use con	tribute to the cau	se of death?
	1	3 ☐ Probably	
24a. Was an	24b.	Were autopsy fir	ndings available

autopsy performed? 26. Place of Dea Other: 4 \(\sum \) Nursing H ER/Outpatient 3 DOA 1 Inpatient

		1∐Yes 2XIN	o 1 Li Yes 2 Li No	
3	th (Cl	neck only one)		
1	ome	5 Residence	6 ☐ Other (Specify)	
	28d.	Describe how inju	iry occurred	
	l			

3 ☐ Suicide 6 ☐ Could not b	2 Accident	investigatio
	3 Suicide	6 Could not b determined

5 Pending

25. Was case referred to medical examiner?

	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		28c. Injury at Work? 1 □Yes	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					

Tiles Zillo	
ry, office	28f. Location (Street and Number or Rural Route Number City or Town, State)

	sician: To the best of my knowledge, death oner: On the basis of examination and/or investant and manner stated.		
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

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31. Date filed (Month. Day. State Registrar

	29c. License	04354	
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29d. Date s	igned (Month, Day, Year)	
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after death Director:

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36455 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200E VOI /Medical 4a. Facility Name (If not institution, give stlat and number) 4c. County of Death 4b. City.:Town, or Location of Death **Examiner** Hospita mare 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-26-1932 9. Birthplace (State or Foreign **Funeral** Social Security Number Age (In yrs. last birthday) Hours Min. 1 □ M 2×C3×F Yrs. 218-26-7436 Maryland 77 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show ir than "natural", or items 23a or 28a-f show 14 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 United States 1826 Spence Street, Apt. 401 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🛣 No Specify: Specify. 3 ☐ Widowed 4 🖺 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle E. Bruchey Edward Prendergast ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra William W. Thomas - Friend 123 S. Arlington Ave., Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 11-12-09 Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Hemostysis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner adenocarcinoma antenown Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 1 Yes 2 Month Year 5 Other (specify) signed by the a d be detached for P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an + has page 2 autopsy perform After this certificate of Vital 1 □ Yes 2 🗆 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Injury at Work? Division Hospital or Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar abatabai

Year)

31. Date filed (Month, Day,

Batimere MD 21223

poleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11 Joseph D. Lazusky 04:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Stella Maris Hospice</u> <u>Timonium</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth If Under 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Director 217-52-5068 60 01/26/1949 Maryland Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No Baltimore N/A 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 21206 U.S.A. 5523 Whitby Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 🗶 No 21215-0036 If Yes, Give 1 Yes 2 X No Specify: Specify: 3 - Widowed 4 - Divorced White Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Benefits Authorizer Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lazusky Estelle Kwiatkowski Dominick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5523 Whitby Road, Baltimore, MD 21206 Donna Lazusky, Wife NOVEMBER Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date . Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 X Other (Specify) Entombment Holly Hill Memorial 11/16/2009 Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ESOPHAGEAL CANCER Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated sease or lingury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes filled in by the funeral director, page 2 should **IOSEPH** 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform<u>ed</u> After this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NO Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred iniury 1 🗶 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contifying Nurse Practioner T. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (c) and in an or accetable. (Check 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar JACKIE

31. Date filed (Month, Day, Year)

JONES,

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

gistrar's Signatu

30. Name and oddress of berson who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death RNARD NOVEMBER 10. 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3415 CLARKS LANE, #E-1 BALTIMORE N/A 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD 8. Date of Birth 218-18-7421 1 XM 2 A Months 85 Hours 1977197 4924 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3415 CLARKS LANE, #E-1 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ FORENSIC ACCOUNTANT CORPORATE ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL G. LEHMAN HORTENSE COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULA SALTZMAN / DAUGHTER 4130 DIXON DRIVE HOFFMAN ESTATES, IL 60192 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State OHEB SHALOM MEM. PARK 11/12/2009 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 21. Signature of Funeral Service License

Pnysician/ Medical Examiner

Physician/

Medical

10a. State

MD

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Funeral

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at.

Baltimore, Maryland 21215-0036

attending physician and Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after dear To the Funeral Director:

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	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between
i n	Immediate Cause (Final disease or condition	CAPDIAC	APREST	- SUDDEN	DEATH		Onset and Death
	resulting in death)						
er	Sequentially list conditions, b	Due to jor as a consequence		<i>ls</i>			
mir	cause. Enter Underlying Cause (Disease or iinjury		=TES				
Ĕ	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):				
dical	U _d	Hyper	tension				
Ř	IF FEMALE:						
Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 Live Birth 2 Fet	al death 3 🗌 Ectopi	c pregnancy		23d. Date of de	
ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 🗆 Other ((specify)		Month	Day Year
y P	Part II. Other significant conditions cont		sulting in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ted b	Renal Hyperla	tailure			1 ☐ Yes	2 No 3 □ P	robably 4 🗆 Unknown
) ple	Hyperla	prde ma			24a. Was an autopsy		topsy findings available completion of cause of
	V 1				performed	? death?	s 2 No
m	25. Was case referred to medical examiner?	# T		26. Place of Death (Che	ck only one)		
욘	T LI Yes 2 LINO	spital: 1	ER/Outpatient 3 🗌	DOA Other: 4 \(\sum \) Nursing F	ome 5 Residence	6 Other (Spec	sify)
ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how inj	ury occurred	
을	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 Yes 2 No			
Medical Certificate:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
흥	29a. Certifier 1 Certifying Physical (Check 2 Medical Examine	ian: To the best of my know r: On the basis of examinatio	ledge, death occured a	at the time, date and place,	and due to the cause(s)	and manner as sta	ated.
ı Ş	only one) 3 Certifying Nurse I	Practioner: To the best of m	y knowledge, death occ	curred at the time, date and plant	at the time, date and pla ace, and due to the caus	ce, and due to the e(s) and manner as	stated.
	29b. Signature and title of certifier	JEF		c. License number	29d. [Date signed (Month	
	1 MACO	. •		D23964		11-10-	09
	30. Name and address of person who com	npleted cause of death (Item	23a) (Type, Print)	- B. 11	na 2	12.48	
- 1	1838 Greenet	ree Rd	Suite 443	Valto	nd V	100	

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State Registrar egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2009 2:46 Shirley Joan Lewis рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death N/A Future Care Charles Village Balto 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔾 🛊 Months Days Hours Min 248-70-6710 Ĩ940 Director 69 S.C. Usual Residence of Decedent show sa or 28a-f shov be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ıral", or items 23a Examiner must be Funeral 135 S. 21202 Exeter Street U S Α Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural", Specify: Black 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+)n / Elementary/Seconday (0-12) Health and Mental Hygiene. tem 27 is marked other tha Home 10th grade 17. Father's Name (First, Middle, Last) Housewife Be 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sinclair Doggett Gladys Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dave Ellis Lewis-Husband 135 S. Exeter Street Balto, MD 21202 Page 1 and 2 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Calvary 11-13-2009 Cem Anne Arundel Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 North Avenue Ε. Balto, MD21202 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and De Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a cor signed by the attending physician and defached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequ Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ধ Unknown certificate has been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes Yes Yes completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Investigation 1 Yes 2 No Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🄁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number D 57088 ricon, m) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rame 21202 salfimor

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

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32. Registrar's

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		1 - State Registrar	olato or mary arri		rtificate of Death	-	Reg. No	36459
Di		1. Decedent's Name (First, Middle, Last)				2. Date of De Month		3. Time of Death
Physici /Medio		Charles 1				1 1	11 2	009 11.50PM
Examir	ier	4a. Facility Name (If not institution, give si			4b. City, Town, or Location of Dea	th	4c. County	
Europa	_	Seasons Hospice C 5. Social Security Number 6. Sex	7. Age (In yrs. la	ıst birthdav)	Randallstown If Under 1 Year If Under 24 Hrs	8. Date of Bir	Baltin	
Funeral Director			M 2□F 70	Yrs.	Months Days Hours Min	8. Date of Bir (Month, Da Aug. 9	, 1939	9. Birthplace (State or Foreign Country West Virginia
pu »		Usual Residence of Decedent	100 000	Town or Lo	anti- n			
laryla sho	ō	10a. State 10b. County						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the N 28a-	rect	Maryland Anne Aru	ndel Cu	rtis .	10f. Zip Code		10g. Citizen of W	
4. In and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Madical Examinar must be nothed at	Funeral Director	4110 Curtis Avenue			21226	Į	Jnited St	tates
ems 2	Iner	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No	- 14. Race	e - American Indian, k, White, etc.
s after	by Fu	1 Never Married 2 Married	1 ∐Yes 2 ZANo IfYes, Give		1 □Yes 2 🕱 No Specify:	,	Specify:	T71a 4 4 a
hours tural	q pa	3 AWidowed 4 □ Divorced	Year or Dates:	16a Dece	dent's Usual Occupation		16b. Kind of Bu	
nin 72	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of work done during most of wo DO NOT use retired)	orking	1051111110	on ossermance y
d with	E O	11	College (1-401 5+)	Cabin	et Maker		Carpen	
be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)	:11		1	me (First, Middle,		e)
y lo	은	Norman Churchill Lo				ne Thomps		
d 2 st d 2 st lth an lth an traur		19a. Informant's Name/Relationship (Typ Norman Scott Lovill/			ng Address <i>(Street and Number or F</i> est 24th Street,		-	
s 1 an of Hea		20a. Method of Disposition				mber 13,		City or Town, State
Page nent count; If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	anoval from State		matory, Inc. 200		Baltimore	e, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Madical Examination once.		21. Signature of Funeral Service Licenses		n 22	2. Name and Address of Facility C1			
Restar		Mulleth			99 Frederick Road	-		
		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death e cause on each line.	Do not ent	er the mode of dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician // /Medical		Immediate Cause (Final disease or condition resulting in death)			lancer			
Examiner			Due to (or as a consequ	ence of):				
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ence of):				
ecuted and transit	Examiner	that initiated events						
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequent	ence of):				
ficate physi s the t	dical	d.						
eath certific attending p for use as t	√Me	IF FEMALE: 23b. Was decedent pregnant	c. If <u>ye</u> s, outcome of <u>pregnar</u>				23d, Date	e of delivery
death death e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other <i>(specify)</i>		Mor	•
at the de	Physician/Med	9 Unknown	9 Unknown					
res tha signed be del	ğ	Part II. Other significant conditions cont	ributing to death but not resul	ting in the u	nderlying cause given in Part I.			ibute to the cause of death?
w requir been s should	Completed							3 Probably 4 ∏/Unknown
The law cate has page 2 s	du					24a. Was auto perfo	osy / p	Vere autopsy findings available rior to completion of cause of leath?
	ပို	25. Was case referred to medical			26 Place of De	1 □ Yes	2 ☑ No 1	☐Yes 2☐No
_ X .s ∃	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier		Home 5 ☐ Resi		or (specify)
ding Ph h. After th funeral	L:uo	27. Manner of Death 1 atural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury			how injury occurre	
tendi seath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □Yes 2 □No	-		
or All after of Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, tarm, str)	eet, factory, office	City or To	Street and Numbe vn, State)	er or Rural Route Number,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur		29a. Certifier 1 Certifying Physi	ician: To the best of my know	rledge, deat	h occurred at the time, date and place	ce, and due to the	cause(s) and ma	inner as stated.
he Ho in 24 h he Fu pletely	edical	(Check only 2 Medical Examination one)	er: On the basis of examinati and manner stated.	on and/or in	vestigation, in my opinion, death occ	curred at the time,	date and place, a	and due to the cause(s)
Viith with Com	Ž	29b. Signature and title of certifier			29c. License number		-	(Month, Day, Year)
		► MSKajapahse M·T.			DOUS 7465		11/1	2109
1 1		30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print) Suite 200, Reis	serstow	n, MD	. 21136
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre/	herred			
		B 1 1 1 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	A Charle /	1 1 . 26 de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Dennis David Minnick 2009 Nov. 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harrford County 1710 N. Fountain Green Road Bel Air 8. Date of Birth (Month, Day, Aug. 25, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, Funeral Months Days Hours Min 1 XM 2 □ F 61 Director 218-46-1743 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Maryland Harrford County Bel Air 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1710 N. Fountain Green Road 21015 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. within 72 hours after 1 Never Married 2 Married Hygiene. Maryland 21215-0036 1 ☐ Yes 2**X** No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Painter Self Employed 10 permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jacob Minnick, Jr. Thelma Padgett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Smith / Sister 1710 N. Fountain Green Rd. Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 2009 Bel Air, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir f Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050 Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final 1cina Cuncer **Physician** netastano disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to (or as a nonsequence of) Examiner Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs page 2 No 1 □ Yes 1 Tes : After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Tesidence 6 Other (Specify, Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ne Hospital or Attending P. n. 24 hours after death. ne Funeral Director: After the 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending nours after death.

neral Director: Af
y filled in by the fur investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mopth, Day, Year) D5484 001 7

&N

State Registrar

DHMH 17 Rev 1/2001

602 S. Atwood St. Bel Air, Maryland 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar s Signature

Phillip Nivatpunin,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 36461 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Morris 200° bea. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Mamiland Medical Center baltimore bathmore 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) April 26,2009 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreigh Country)
 New York 7. Age (In yrs, last birthday) **Funeral** Hours Min. 1 □ M 2 🙀 F 097-98-4195 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Hean 27 Is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, it is included. Director 1 ☐ Yes 2 😿 No Maryland 1 4 1 Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 6233 Bird Race 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🔼 No If Yes, Give Year or Dates: Specify: ð Specify: Multi-Racial 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christopher Joel Morris Lisette Renee Soudant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisette Renee Morris (Mother) 6233 Bird Race Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11-6-2009 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Witzke Funeral Homes, Inc. 5555 Iwin Knolls Koad Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonam dow /Medical Due to (or as a consequence of): Examiner Seas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed da attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of D ath 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number

State Registrar

2

maya a maturo

A. Martino-

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cardona

32. Registrar's Signature

DOD 68781

MD

22 S. Greene St. Bultimore

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# I/perffl, 6897, 117, 20709, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician CKLA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECRUBS BALTIMORE HOJEITHL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 3-18-1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2**X**□ F Months Days Hours 81 215-28-6499 Director N.C. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, it e Medical Examirur must be rectified at Director 1 Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2744 Mura Street 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Black ≥ Specify: ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)n/a Elementary/Secondary (0-12) J. H. H. 12th grade Nurse Aid 17. Father's Name (First, Middle, Last)
Harris
William Vanderbilt 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Mollie Williams ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Butler-daughter 2744 Mura Street Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cem 11-13-2009 Balto, 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee dup la 1101 E. North Avenue Balto, MD 21202 Wane Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): SACRAL DECUBITUS ULCER Examiner INFECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Po Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy To the Hospital or Attlending Physician: The within 24 hours after dea h.

To the Funeral Director After this certificate I completely filled in by the funeral director, page FAILURE 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mognotely, mo 0149,49 lone7 V. 11/9/11/9/ 11/9/

DHMH 17 Rev 1/2001

State

Registrar

EALTIMONE,

m)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. MOBHATU

31. Date filed (Month, Day, Year)

1

3 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Pegible? State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Joseph Earl Mooney Jr. 2:35 PM 10 2009 Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/ABaltimore 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days April Day Year) 1959 Months Hours Min Mary land 50 Director 218-78-1141 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f N/A 1 X Yes 2 No Maryland Baltimore 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4418 Parkton Street 21229 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. o 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. \$ 1 Yes 2 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marked any injury or other traumatic any Joseph Earl Mooney Sr. Bétty Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bètty Mooney, Mother 4418 Parkton Street Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/12/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee R. Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) WKS Due to (or as a consequence of): Medical **Examiner** esoprageal-grewal Sequentially list conditions, if my Label 2 to 1, 1, 2 at cause. Enter Underlying Examine ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury esophageal cancer - metastatio months that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year detached the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 No Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autonsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No ours after death.

eral Director. After this certific.
filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Abdallah, MD

State Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Records,

Division of Vital

32. Regisfrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abdallah

31. Date filed (Month, Day, Year)

AT 2438946

parko

, Union memorial Hospital, 201 E. University Partway, Baltimore, MD 21218

11/10/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Month Year McDonald homas Vovember 2009 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL N/A timore 4arbor If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 Year Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Min Yrs So. Carolina Jan 25, 1961 48 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S.A 417 Roundview Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Black Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen McDonald Nathaniel McDonald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Roundview Road Baltimore, Maryland 21225 Terrence Frazier 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/09/09 Catonsville, Maryland Metro Crematory, Inc. 21. Signature Juneral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 212 23a. Part 1. Inter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Metabolic disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of) Pat 1 resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **D**No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No

Physician /Medical **Examiner**

physician

has

certificate

this

within 24 hours a To the Hospital

Medical

law requires that the death certificate be executed

P.O. Box 68760

Records,

of Vital

Division

Physician:

Department of Important: If it any injury or o

Physician

/Medical

10a. State

Director

Funeral

2

Completed

Be

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Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nont of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Saltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Examiner Physician/Medical þ Completed Be

burial-tran as the nse ρ signed by the a plnods page 2 Certification: To funeral spital or Attending Prous after death.
neral Director: After /

27. Manner of Death 1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 🗌 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

5 Pending investigation

6 ☐ Could not be

determined

Street, Baltimore, MD 21225

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7,001 South

29b. Signature and title of certifier

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36466 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 2009 NZotta 2130 M Constance 11 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimor Hospital ER-Randallshown Northwest If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Months Days Hours 1 □ M 2 ⋤ F 217**-**85**-**9429 14 Nigeria Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 □ No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6814 Sauter Lane 21207 Nigeria 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ No Specify: Specify: Black 37☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12th grade 2yrs Grade School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Svlvanus Eke Ololo Lydia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celia U. Ogbonna-Daughter 6814 Sauter Lane, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aba, Abia State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nzotta Family 12/30/09 Nigeria 22. Name and Address of Facility March F/H West 4300 Wabash Ave, baltimore, Md 21215 Signal re of Funeral Service License 23a. Par /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrhythmia Due to (or as a consequence of): ali sease COTONOTY arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) hypertension Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an 1 ☐ Yes 2 💆 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 💆 ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, its Modical Exercitivat and.

Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

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the Maryland

death with

/Medical

Physician/Medical ξ Completed Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

n 24 hour the Funeral Dire within 24 hor To the Fune completely f

State Registrar

Medical

29a, Certifier

(Check only one)

25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death 1 🔀 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title of certifier MD

D \$\$68783

Hospital -ERT

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael of with mp, Northwest 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Barlos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Karen Louise Nace /Medical 11/11/2009 7:52 A^M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol1 Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) 7/26/1955 Birthplace (State or Foreign Country) Days 1 M 2 XF Months Hours 212-70-7644 54 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 No Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4950 Fleming Rd. 21771 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Narried 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: þ 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Her Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Michael F. Armetta Gloria Mary Amadio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Nace/Husband 4950 Fleming Rd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1KD Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dønation 5 □ Other (Specify) Taylorsville Cemetery 11/16/2009 Taylorsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility. Burrier-Queen Funeral Home & Crematory, P.A. allin 1212 W. Old Liberty Rd., Winfield, MD 21784 rt 1. Iter the disease, or complications nock, ir heart failure. List only one cau complications that caused the death. only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Im ediate ause (Fi distase condition res ltir in death) ause (Final Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or Itijury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4 ☐ Pregnant at time of death Month 5 ☐ Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 □ Yes 3 Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only on 1 ☐ Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 D 27. Manual of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

ours after death. eral Director: After this certificate has been signi filled in by the funeral director, page 2 should be thin 24 hours a

Funeral

Director

iral", or items 23a or 28a-f show Evaminar is ust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. It was the statement of the stateme

Physician

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Examiner

Physician/Medical

Be Completed by

Certification: To

29a, Certifier (Check only one)

Baltimore, Maryland 21215-0036

29d. Daye signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 Yousuf Jaffar S. Center St., Westminster, MD 21157

31. Date filed (Month, Day State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#26perPHYS, G897, 11 / 13/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 9 36468 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles L. Randolph 2009 6:30 A^{M} November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Abby Manor Assisted Living Elkton Cecil If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Pennsylvania 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1**X** M 2□ F 213-01-5818 Jan. 26, 1916 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State traumatic event, the Medical Examinar must be notified at Cecil Elkton 1 ☐ Yes 2☐ No **Funeral Director** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 USA 1 Colonial Court 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Chemical Company Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellen M. Kelly Lewis B. Randolph ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21074 19a, Informant's Name/Relationship (Type, Print) f Health Patricia Graefe/ Niece Road-Hampstead-Maryland 4540 Black Rock permit. Pages 1 a
Department of Her
Important: If Item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Parkwood Cemetery Nov. 14,2009 Parkville, MD 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) DI5QUE Obstructive Kulmonary **Physician** /Medical Due to (or as a consequence of) Examiner Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) 9 Dlinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home \frac{5 \overline{\text{Pincheck only one}}}{5 \overline{\text{Pincheck only one}}} \frac{6 \overline{\text{Voltner}}}{6 \overline{\text{Voltner}}} \frac{6 \overline{\text{Voltner}}}{6 \overline{\text{Voltner}}} \frac{6 \overline{\text{Voltner}}}}{6 \overline{\text{Voltner}}} \frac{6 \ove Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0023322 11, 13.2009. 8my ablaces 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) High St Elpton MD 21921. 126 A, E SACHDEN MD 32. Registrar's Signature 31. Date filed (Manth State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NÖVEMBER REED 2009 1:48 A Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Hours Min 06-03-1936 **Director** 215-30-3612 73 Usual Residence of Decedent show filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 🗌 Yes 2 💢 No BALTIMORE REISTERSTOWN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 321 LEYTON ROAD 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. 9 Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 ▼ Widowed 4 □ Divorced Year or Dates WHITE marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LEVIN MAX FANNIE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY REED/SON 8020 HARRIS AVENUE, BALTIMORE, MD 21234 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🖵 Removal from State HAR SINAI 11-12-2009 OWINGS MILLS, MD 4 Donation 5 Other (Specify) 21. Signature of Puneral Service 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or iinjury Due to (or as a consequence of) Physician/Medical Exam or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant a Month Dav Year Pregnant at time of death 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performed this certificate completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t 28d. Describe how injury occurred Natural work? 1 Yes 2 No 5 \square Pending Accident Investigation Suicide
Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32

State of Maryland / Department of Health and Mental Hygiene. Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 12:50 PM 2009 Anna R. Rahl /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbur at the L 160MICO Hospice Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🛱 F 131-01-8916 Director Sept 27, 1918 | New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Director Worcester Berlin 1 ☐ Yes 2 ▼ No 10e. Street and Number 218 Windjammer Road 10f. Zip Code 10g. Citizen of What Country? 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 Is marked other the any Injury or other traumatic event, If any Once. housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Garfinkle Abraham Rosensweig ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Apson/daughter 220 Windjammer Road Berlin, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 ☐ Other (Specify) 21. Signature of ineral Service Licensee Ranald S, Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, one art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CBRRBROVASCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in a sequentially list conditions, in a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the "trending pryssician and tending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PM0 1 🗌 Yes 3 Probably 4 Unknown this certificate has been siral director, page 2 shoufd Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) filled in by the funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUIAN WAR 31. Date filed (Month, Day, Year) NOV 1 3 2009 State Registrar

AZZA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month 4c. County of Death Town, or Location of Death Facility Name (If not institution, give street and number) 4b. City, Date of Birth (Month, Day Age (In yrs. last birthday) Hrs. Min. Months Hours Days 1 M 2 2 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City Tewn or Location -1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? Street and Numbe 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 12 No 1 ☐ Yes 2 2 10 Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 18. Mether's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Mungillack MO 21758 20c. Location - City or Town, State 20a. Methed Disposition Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) an 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21701 FREDERICK MO WEST SOUTH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAIN TUMOR MALIGNAN disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

the

attending pl

ed by the detached t

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icate has been si

certificate

: After this certific funeral director,

Physician /Medical

Examiner

10a, State

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Exactions must be notified at

Funeral Director

<u>2</u>

Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nd Mental Hygiene. marked other than

f Health and Mental H tem 27 is marked oth

Department of Health Important: If item 27 any Injury or other trong once.

Maryland 21215-0036

Baltimore.

Box 68760.

P.O.

Records,

of Vital

Division

Hospital or Attending Physician: The

death.

within 24 hours after death To the Funeral Director: completely filled in by the

Examiner sician and burial-transit law requires that the death certificate be executed

Physician/Medical

Completed by

Be

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Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 🗷 No

IF FEMALE:

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a, Certifier

Due to (or as a consequence of):

If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 ☐ Unknown

24a. Was an autopsy 2 No 1 ☐ Yes

Other: 4 ☐ Nursing Home 5 ▶ Residence 6 ☐ Other (Specify)

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 TYes

25. Was case referred to medical examiner? 1 Inpatient 27. Manner of Death

5 Pending

28a. Date of Injury (Month, Day, Year) investigation 6 Could not be determined

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier D CRNP

R097025

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

1550 ORLEANS STICRB 2.1M-16, BALTO, MD 21231 CRNP FERRIGNO

0 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 22 State of Maryland 1/10 enartment of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MOBV **Physician** 2000 730 A M KUFF ALLLE /Medical 4b City, Town, or Location of Death BACTIA ONE 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HUSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Gountry)
GEOPGIA 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 KF Days Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 1 Yes 2 No Be Completed by Funeral Director timon 10g. Citizen of What Country? Street and Number 7 is marked other than "natural", or items 23a traumatic event, the Medical Experience in ust Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 3 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Mother's Name (First, Middle, Maiden Sum: 17. Father's Name (First, Middle, Last, Pages 1 and 2 should be finent of Health and Mental Annie ဝ Informant's Name/Relationship (T 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 360 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra once. Baltimore, 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral S 119-121 S. Stricker St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SDIRATION Physician /Medical Due to (or as a consequence of): Examiner Kr our Bowe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be execu burial-tran Due to (or as a consequence of). Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 □ Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an or Attending Physician: The Vital 1 □ Yes 2 □ 1No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA ō 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of cortifier

State Registrar

DHMH 17 Rev 1/2001

ST

32. Registrar's Signature

PAUL PLACE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COSTA

JOSEPH

31. Date filed (Month, Day, Year) **2009**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36473 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 24 Hrs. Min. last birthday) 8. Date of Birth 7. Age (In yrs 9. Birtholace (State or Foreign **Funeral** Months Days Hours Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? ö Funeral 2 23a 234 5 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 12. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 (1) hite 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) 5 Other (Specify) ight I of Full eral a rvice Lice see 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 2000 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a sunsequence of bunial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 as the l IF FEMALE ase yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death signed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \sum Yes 2 **2**No 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Deat 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701

MO

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:25 A.M November 2009 June Mary Simus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Golden Living Nursing & Rehab. Center 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 4, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 1 F 214-14-5287 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinations to be notified at 1 ☐Yes 2 ☑ No Director Baltimore Maryland Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 Ballycruy Ct. 21093 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Young ೭ Mary Hannel 19a. Informant's Name/Relationship (Type. Print) (Daughteit) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pamela S. Koehler 171 Federal Ann Ct. Westminster, ND 21157 altimore, 20b. Place of Disposition (Name of Cemptery, crematory or other place)
Druld Ridge Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 16, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Park Heights, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Cutr, P.A. 21. Signature of Funeral Service Licenses York Rd. Timonium, Maryland 23a. Part 1 Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-tran Due to (or as a consequence of) attending physician for use as the buria Box 68760, Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) □Yes 1 ☐ Yes 2 No 9 ☐ Unknown signed by the a d be detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☐No 2 **K**lo 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 the 29d. Daye signed, (Month, Day, Year) 29c. License number 29b. Signature 31. Date fled (Month, Day, 32. Redistrar's State Registrar

amend #35 Per of Waryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:00AM 20, 2009 Oct. E. Schools Ernestine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Hours 1 □ M 2 🛛 F 21,1945 Maryland 213-56-7643 April 64 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Sa or 28a-f show the notified at 10b. County 10a State 1 X Yes 2 No Funeral Director Rockville Montgomery MD 10g. Citizen of What Country? 10e. Street and Number death with 20850 USA 311 Frederick Avenue 23a event, the Medical Examinar nust Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐Yes 2 XNo Specify. Specify: Black 2 3 Widowed 4 Divorced 'naturai", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Bus Attendant permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event. It is 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mable L. Mercer Willie L. Schools ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3506 SOftwood Terrace Olney, MD 20832 19a. Informant's Name/Relationship (Type. Print) Debbie S. Smith/Daughter Olney, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 10/22/\$9 Beltsville, MD 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Lig 3821 14th Street, N.W., Washington, DC20011 M00996 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final 10 lish lmo minutes **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No certificate 1 □Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shady Grove Hospital Rockville, MD 20850 Martin Thai McGreivy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19b, perFH, G897, 11/13/09, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 23:34 M Physician/ SOLOSTYANSKAYA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital o Baltimore CI N/A Baltimore If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) RUSSIA 5. Social Security Number Age (In yrs. last birthday) Funera 1 M 2 X Days 10-04-1919 Director 218-33-9356 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State Director REISTERSTOWN 1 🗆 Yes 2 🗶 No MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21136 302 CANTATA COURT, death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 X No Black White etc. 1 Never Married 2 Married þ 72 hours after Maryland 21215-0036 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PHARMACY PHARMACIST 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN SOLOSTYANSKAYA BELLA BORIS traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12517 FELLOWSHIP COURT, BALTIMORE, MD 211 Reisterstown 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MD 21136 MARINA BARNANOFSKY/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 11-12-2009 REISTERSTOWN ,MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROTHERS, INC. 22. Name and Address of Facility 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final cardiogenie Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician a the burial-1 Physician/Medical requires that the death certificate be P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown the g Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failuse Heart 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has Fibrillation performed' 2 No Yes ☐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗌 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Gramatskova MD NPI 1124255450 and address of person who completed cause of death (Item 23a) (Type, Print) Simai Hospital of Ballimore PGV 6 ramatiko va 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SCHNELL 04:45 PM CHRISTOPHER 2009 NOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Vear 1**∑** M 2□ F 215-80-9843 47 1962 England Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√Yes 2□No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 1504 Covington Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 □Yes 21X No Specify ģ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) therapist healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be William Schnell Mildred Schnell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Schnell/spouse 1504 Covington Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronal d S Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 3a. Part. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or condition resulting in death) MASSIVE HEMOPTYSIS Due to (or as a consequence of): MAC PNEUMONIA Sequentially list conditions,

Physician /Medical Examiner

Funeral

Director

show

ir than "natural", or items 23a or 28a-f show

10.

alth and Mental Hygiene.

27 is marked other than "r
r traumatic event, "h

Department of Health a Important: If item 27 is any Injury or other trains

Pages 1

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-tra attending physician for use as the buria signed by the a d be detached for filled in by the

Division of Vital Records, P.O. Box 68760,

Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	,			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of 9 □ Unknown	Il death 3 🗆 Ectopic		2	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
				24a. Was an autopsy performed? 1 □ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🛭	OA Other: 4 Nursing	Home 5 ☐ Residence 6	Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	ysician: To the best of my knowinger: On the basis of examination				and manner as stated, place, and due to the cause(s)

29c. License number

RES 000

30015 HANOVER ST BALTIMORE MD

29d. Date signed (Month, Day, Year)

2009

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 3 2009

29b. Signature and title of certifier

SYED MUSTAFA AHMED Registrar's Signature

and manner stated.

M-D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24 hours a

To the Hosp within 24 hor To the Fune completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 11:42a M Jeffrey Howard Stanton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Balto Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Days Hours Min. M4nth; Pay, 19968 MD 41 Director 214-92-4673 Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4240 Labyrinth Road 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) 2 year BALTO County the years Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thelma McNair William Stanton permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood, MD 21040 2937 Ancon Ct Valerie Anderson-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-12-09 Garrison Forest Owings Mills, March East F/H re of Funeral Service Licen 22. Name and Address of Facility 1101 E. Balto, MD 21202 North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COMPLICATIONS MEGG Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the at Id be detached for Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has page 2 this certificate 1 TYes 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 **N**O 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💢 Other (Specify) ₩ 5 🤉 (C 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: ...er of D 1 Se Natural 2 ^ ^ 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours a 'er death.

To the Funeral Director: Affer (Month, Day, Year) work?
1 Yes 2 No injury 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) 150 701 32. Registrar's Sign State

Registrar

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			1 Decembris Name (First Middle Leet)		tificate of D	<i>Jealii</i>		2. Date of Dea		109	3 D 4 / 3
	Physicia /Medic	an	John	Thi	weatt			Novem	her 10	, 2009	4:55P M
	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City				4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day)9 22	Year) 58	9. Birthr Coun	place (State or Foreign try) MD
	D	1	Usual Residence of Decedent	orlo	cation						10d. Inside City Limits
	larylar r shov	5			imore					1 XYes 2 □ No	
	the N	Director	10e. Street and Number		10f. Zip-Code				10g. Citizen of	What Cour	ntry?
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	r deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.1	Was Decedent of Hi f Yes, specify Cuba	spanic Or n, Mexicai	rigin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		ace - Americ ack, White,	
36	be filed within 72 hours after death with the Maryland ttal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 ☐ Yes No If Yes, Give Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 XNo	Specify:	:		Spec	ify: Bla	ack
21215-0036	2 hou		15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	st of workir	ng	16b. Kind of	Business/In	dustry	
215	ithin 7 ne. Nedi	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	life.	DO NOT use retired)) _			Di	sabl	ьq
2	filed withi Hygiene. other than		12th grade na 17. Father's Name (First, Middle, Last)		Disable		ner's Name	(First, Middle,			
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ary	s 1 and 2 should by f Health and Menta item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street						
	1 and 2 Health a em 27 is		0111 / 1111		3 Moore				20c. Location		
Baltimore,			20a. Method of Disposition 1 ▼Burial 2 Cremation 3 Removal from State 20b. Place of cemeter.	t Dispo ry, crei	osition (Name of natory or other place	e)		ate		•	
<u>=</u>	'교투뚜를	1	↑ Donation 5 ☐ Other (Specify) King 21. Supartule of Funeral Service Licensee)	Me:	morial F 2. Name and Address arch F/F	ark ss of Eacil	LIT/	10/09	WOOGI	awii,	ma
g	Depar Impor any ir		1 Ply 5 Teke	M.	arch F/F 300 Waba	ash .	st Ave,	Balti	more,	Md	21215
			23a. Palt 1. Enter the disease, or complications that caused the death. Do n shock, or hear failure. List only one cause on each line.	not en	er the mode of dyin	ng, such a	s cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
4	Physician	30 (3	Immediate Cause (Mai disease or condition a. Runal Foulus)	e						1	Onset and Death
4	/Medical Examiner		resulting in death) Due to (or as a consequence of the control of	of): <i>0</i>							
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7	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events								
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89 X	death certificat attending phy d for use as th	M/m	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	2 [Tectonic prognance					Date of deliv	
P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as t	Physician/M	in the past 12 months? 1		Ctopic pregnancy Other (specify)	у				Month	Day Year
0.	at the by th		9 Unknown Part II. Other significant conditions contributing to death but not resulting i	in the	underlying cause gi	iven in Par	rt I.	23e. Did t	obacco use c	ontribute to	the cause of death?
g,	ires th signed d be c	d by	Takin Ginor Signingan Comments Sample					1 🗆 '	Yes 2 □ No	3 🗆 Pro	bably 4 nknown
Records,	v requ	Completed						24a. Was		b. Were aut	opsy findings available ompletion of cause of
æ	The lay e has age 2	omb						perfo	rmed? 2 No	death?	2 🗆 No
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<u>5</u>	hysic his ce al dire	욘	1 ☐ Yes 2 ☑ No Rospital 1 ☐ Impatient 2 ☐ ER/Ou	tpatie	1 3 L DOA	4 L N		ne 5 Residence R		_	fy)
O	ding P h. After t funer	tion:		Injury	Worl	k? Yes 2			,,		
Division of Vital	Attendi	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)	rm, st	reet, factory, office			28f. Location (mber or Ru	ral Route Number,
	tal or A rs after al Direc led in by										atatod
	To the Hospital or Attending Physician: The law requires that the dewintin 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier (check only one) 1—Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, aeat nd/or it	n occurred at the tir nvestigation, in my c	opinion, de	eath occur	red at the time	date and pla	ce, and due	to the cause(s)
	To the vithin to the comple	Mec	29b. Signature and title of certifier		29c. Licenso				29d. Date sig	ned (Month,	Day, Year)
B			I Qualino Kal		RES	-00	U		Nove	niber	10.2009
	3		30. Name and address of person who completed cause of death (Item 23a)	(Туре	, Print)		600	North Wa	olfe St F	3altimo	re, MD, 21287
	Sta	te	SITALINE RAO 31. Date filed (Month, Day, Year) 32. Bristrar's Signature	organization and	0		3001	TOTAL MAC	Ot, L		,,
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Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanirar must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> 3 Sta Registr DHMH 17 Rev 1/2001

	1 - State Registrar			Ce	rtificate	e of L	Death			Reg.	No. Z U	09	30400
	1. Decedent's Name (First, Midd.	le, Last)							2. Date of	Death			3. Time of Death
ın	JORD	AN JOSEPH	VOGEL						Month OCT		Day 2009	Year	10:05 A ^M
al er	4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, 7	Town, or	Location	of Death			4c. County	of Death	
C1	NATIONAL N	AVAL MEDI	CAL CEN	ΓER		BE'	THEST	A			М	ONTG	OMERY
_	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday,) If Under		If Under		8. Date of I	Birth		9. Birth	place (State or Foreign
	N/A	1 ½ M 2□ F		Yrs.	Months	Days	Hours 1	Min.	0ct	17,	2009	Mar	yland
	Usual Residence of Decedent	1											
	10a. State 10b. County	'	10c. Ci	ty, Town or Lo	ocation								10d. Inside City Limits
tor	DC		Wa	shingt	on								1X Yes 2 ☐ No
rec	10e. Street and Number				10f. Zip	Code				10g.	Citizen of \	What Cou	ntry?
	2403 E Street,	NE			200	002				US	: Δ		
era	11. Marital Status		cedent Ever in U	.S. 13.	Was Decede		ispanic Or	igin? (Sp	ecify Yes or	1 -	_	e - Ameri	can Indian,
Fur	1 Never Married 2 ☐ Mar	Armed F	orces? 2 🔼 No		If Yes, speci	ify Cuba	n, Mexica	n, Puerto	Rican, etc.)		Bla	ck, White,	etc.
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes. G	ive		1 ☐ Yes 2	⊠ No	Specify.				Specif	/: W]	nite
ed	15. Deceder	nt's Education		16a. Dece	edent's Usual	I Occupa	ation			16b	. Kind of B	usiness/Ir	ndustry
plet	(Specify only highe	est grade completed		(Give	e kind of worl DO NOT use	k done d e retired	luring mos ')	t of work	ing	-			
mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	N/A	7						N/A		
Be Completed by Funeral Director	17. Father's Name (First, Middle,	, Last)					18. Moth	er's Name	e (First, Midd	lle, Maio	den Surnan	ne)	
To B	Nicholas Lee V	loge1					S11.7.2	anne	Marie	DuF	lain		
Ĕ	19a. Informant's Name/Relations			19h Mail	ing Address	(Street a						State. Zi	n Code)
	Nicholas Lee V		hor		B E. St						-		
	20a. Method of Disposition	oger, rat	20b. I	Place of Disp	osition (Nam	ne of	- 1		Date		. Location		
	1 ☐ Burial 2 🛱 Cremation		State F11	cemetery, cre neral	matory or oti Choice	her place	- :		. / 0 0 0 0	01		· • •	
	4 □ Donation 5 □ Other (8		Cha	ntilly		al A alaba a							irginia
	21. Signature of Funeral Service	Gary "Co	R. Dow	mer '							ices (ot Ch	antilly 20151
-	30000 (NEW)	My #ccc			.4522L					-	_	зтита	
	23a. Part1. Enter the disease, o shock, or heart failure. Lis	t on one cause on	each line.	th. Do not er	nter the mode	e of dyin	g, such as	cardiac	or respirator	y arrest,			Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	EXT	REME PRI	MATUR'	TTY								Onoot and Death
	resulting in death)		o (or as a consec										
	Sequentially list conditions, b.												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
cam	Cause (Disease or injury that initiated events resulting in death) Last	с	,		con of):								
Ω.	resulting in death) Edot	Due to	o (or as a consec	quence or):	:e ot):								
dica		d										_	
Me	IF FEMALE:												
an/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 🗌 Feta	al death 3	☐ Ectopic pr	regnancy	У			23d. Date of delivery Month Day			very Day Year
Sici	1 ☐ Yes 2 ☐ No	4 ☐ Pre 9 ☐ Uni	gnant at time of nown	death 5	Other (spe	ecify)						Jirar	Day Tour
Completed by Physician	9 Unknown	lana an italia ii	death to t	udain — t - d	o a al a site d		ande District		00- 0	id toh	00 1100	tribute to	the cause of dooth?
þ	Part II. Other significant conditi	ions contributing to	uearn but not res	outting in the t	underlying ca	ause give	en in Part	1.					the cause of death?
ted									1	Yes	2 X NO	3 ∐ Pro	bably 4 Unknown
ple									24a. W	as an itopsy	24b.	Were aut	opsy findings available ompletion of cause of
E O									1 X Ye	erformed	1? 1 No	death?	2 ½ No
Be C	25. Was case referred to medica	al				26. Plac	e of Deat	h (Check on		1140	1 1 1 1 1 2	2,43110	
	examiner? 1 ☐ Yes 2 反 No	Hospital:	Inpatient 2] ER/Outpatie	ent 3 🗆 DO	Othe	er.		ome 5 □ R	-	e 6 DOt	ner <i>(Spe</i> c	ifv)
n:-	27. Manner of Death	28a. Dat	e of Injury	28b. Time		8c. Injury Work			28d. Describ		-	- , ,	,,
tio	11 Natural 5 ☐ Pendil 2 ☐ Accident invest	ng (Wo	nth, Day, Year)	Injury	М		r Yes 2 □	No					
fice	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At h	ome, farm, st	treet, factory,	office			28f. Location	(Stree	t and Numi	ber or Ru	ral Route Number,
ert	4 ☐ Homicide determ	Buili	aing, etc. (Speci	iy)					City or	Town, S	tate)		
a	29a. Certifier 1 Certifyi	ng Physician: To the	ne best of my kn	owledge, dea	ath occurred	at the tin	ne, date a	nd place,	and due to	the caus	se(s) and m	nanner as	stated.
Medical Certification: To	(Check only 2 Medica one)	I Examiner: On the	basis of examin nner stated.	ation and/or i	investigation,	, in my o	pinion, de	ath occur	red at the tin	ne, date	and place,	and due	to the cause(s)
Me	29b. Signature and title of cortile	er			290.	. License	e number			29d.	Date signe	ed (Month	, Day, Year)
) (_	#11	1	Car		0101	12290	45 (VAI		200	9 1	XT 23
	30. Name and address of persor	who completed car	use of death (Ite	m 23a) (Tvne					NAVAL				
			USN	, (1) po					MD 208				-
te	31. Date filed (Month, Day, Year		Registrar's Sign	ature									
ar	MOV 1 2 200	19 6	1	Land	D								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 36481 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Marquerite Anne Ward 2009 2:50 P November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Country) Stella Maris Tinoniun
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/20/1917 5. Social Security Number 7. Age (In yrs. last birthday) Days Min. 1 □ M 2/□ F Months Hours 92 Yrs 213-01-0927 Balt., Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Harford Bel Air 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 2608 Creswell Road 21015 of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrator <u>Dental Office</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Bradin Mary Coan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William D. Smith/ nephew 2608 Creswell Road Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 10, 2009 Forest Hill, Maryland Peacerul Afternatives Funeral & Cremation Ctr., P.A. 21. Signature of Funeral Service Licenses 2325 York Road Timonium, Maryland 21093 23a. Part1. Envir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

2

Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any julyor or other traumatic event, it is Medical Examinationals be notified any julyor or other traumatic event, it is Medical Examinationals be notified.

Baltimore, Maryland 21215-0036

:45

Examine physician

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<u>5</u>
Be Completed
Be (
Certification: To
ā

Medic

State Registrar

31. Date filed (Month

use as the burial-tran Box 68760 P.0. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

MARGUERITEA

in the past 12 months? 1 ☐ Yes 2 ☐ to 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown			Month Day Year					
Part II. Oth sirricant conditions		sulting in the underlyin	g cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown				
				24a. Was an autopsy performed' 1 ∐Yes 2					
25. Was case referred to medical examiner?			26. Place of	Death (Check only one)					
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Trising Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death Natural 5 Pending 2 Accident investigati		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred				
3 Suicide 6 Could not determine		nome, farm, street, fact	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)				
	Physician: To the best of my kn aminer: On the basis of examin and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)				
29b. Signature and title of certifier	Li mo		29c. License number	74	Date signed (Month, Day, Year) OVEMBER 10, 2009				

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

EDDIE NAKHUDA, M.D.

State of Maryland / Department of Health and Mental Hygien 20091 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10, Nov. 2009 6:30P Stephen Douglas Wamsley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Nottingham Baltimore 70 Powder View Ct. 8. Date of Birth (Month, Day, Year) 2/29/1984 Birthplace (State or Foreign Country)
 M If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min 1**X**M 2□ F 220-23-4158 25 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at MD Baltimore Nottingham 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 70 Powder View Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Emerge, Inc. Elementary/Secondary (0-12) College (1-4or 5+) Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Patrice Wamsley David Wamsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Department of Health and Important: If Item 27 ie m any injury or other traun once. Rachel Lewis Wamsley/Wife 70 Powder View Ct. Nottingham, MD 21236 20c. Location - City or Town, State Beltsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. Novoate 13, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit CAFA/Stephen D. Lohrmann P.A. MO1585 21. Signature of Funeral Service Licensee, Rebecco Hackeman 8717 Green Pastures Dr. Balto, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Asphyxla 6 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pt for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an certificate has autopsy page performe 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 🗆 Nursing Home 5 Residence 6 □Other (Specify) 2 No 2 ER/Outpatient 3 DOA 2 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending Notion 10 2009 1 8/30 P M 1 = 28e. Place of Injury. At home, farm, street, factory, office building, etc. (Specify) thours after death. unerel Director: Aftely filled in by the fur Suicide by hanging investigation 2 Accident Number or Rural Rouge Number, TO Powder View CT. 6 Could not be determined 3 Suicide 4 Homicide City or Town, State) within 24 hours af To the Funerel D Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie who completed cause of death (Item 23a (Type, Print) 30 Name p Militello, MD 6 Trimble Hill CT. Luthervillo, Md 21093

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month White 4.50 am lohan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death Joseph Richey Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** XXM 2 DF Days (Month, Day, Year) Months Hours Min. Director 70 248-64-5305 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 XYes 2 No Baltimore MD NA 10e. Street and Number ō 10g. Citizen of What Country? Funeral U.S.A. 23a 21229 3320 Edmondson Ave items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black, White, etc. þ 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Meat Factory 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Williams permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Robert White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 1123 North Calhoun Street, Baltimore, Teresa White-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md 11/14/09 Memorial Park 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, 2/4 Md 21215 baltimore, Pint 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CONTON byûm bone and advers disease or condition Medical resulting in death) Due to (or as a consequence up **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and s the bunal-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pathological tracture of Vital Records, Completed 1 🗌 Yes 2 🔲 No 3 Probably 4 Unknown Coronacy Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25 25. Was case referred to medical Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident or Attending Division C 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1. Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

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egistrar's Signatur

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:45 AM Robert L. Wheeler 2009 HOVE MISEIZ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMOR AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, AUg 24, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Maryland 1 X M 2 □ F 212-60-6611 57 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evancher must be notified at 1X Yes 2 ☐ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 3951 Benzinger Road #312 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 MYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ∐Yes 2**X** No Specify. Completed by **'**69**-**71 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be T. Ernestine Loucks Joseph R. Wheeler ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 3951 Benzinger Road #312 Baltimore, MD 21229 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. Michele A. Wheeler/spouse Pages 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signatur Ponal de Persee Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNKNOW FI **Physician** METASTATIC THROAT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequence of) Examine the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 2 🗆 No 1 ☐Yes 2 ☐No 1 □Yes of Vital Physician; 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 N 1 Impatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division Hospital or Attending 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 80060105 HOVEMBER 72009 ed cause of death (Item 23a) (Type, Print) Name and address of 900 SCATON AVENUE BALTIMORE 21225 HERSON MIX 31. Date filed (Month, Day, Year) State 3 2009

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan		rtment of H			2.01	09 36485
			Decedent's Name (First, Middle, Las	t)		imodic or i		2. Date of Deat	1	3 Time of Death
	Physicia /Medic		Lola Mae Lorrai	ne Weaver				October	30°, 200°	9 ^{ar} 3:15 PM м
	Examin		4a. Facility Name (If not institution, give 3718 Park Over1	· ·		4b. City, Town, or Ellicot	Location of Death		4c. County of Howar	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	,,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	87	Yrs.			Mar 23,	1922 \	Virginia
a de	Mo to		10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
Mar	f sh	ţo	MD Howard	F	Ellicot	t City				1 □Yes 2√□No
d d	or 28)jre(10e. Street and Number		-	10f. Zip Code		1	g. Citizen of Wha	at Country?
the wi	23a	by Funeral Director	3718 Park Overloo	k Court			21042		USA	
20	items	nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, White, etc.
میر م	l', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 M No If Yes, Give Year or Dates:	1	□Yes 2∏ No	Specify:		Specify:	white
Z 1 5-0036	atura	ted	15. Decedent's Edu	ucation	16a. Deced	lent's Usual Occupa	ation	1	l 16b. Kind of Busin	ness/Industry
1 hin 7	an 'n	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give I life. D	kind of work done o OO NOT use retired	furing most of work)	king		
Q Z I Z I 3-0036 filed within 72 hours after death with the Maryland	lygier her th		12	0		housewif			own hor	me
yrand wild be file	ed otl	Be	17. Father's Name (First, Middle, Last) Claude Charles T	ravlor			18. Mother's Nam		,	
	nark mark matic	욘	19a. Informant's Name/Relationship (7		10b Mailin	g Address (Street a		e May Fi		oto Zin Codel
3 3 3 3 3 3 3 3 3 3	alth ar 27 is r trau		Larry A. Weaver/s			Wayside			-	21029
	of Hear Item		20a. Method of Disposition	20b. Pl		sition (Name of natory or other place			20c. Location - Cit	
altimor	Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It's Medical Examinar must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☑ Donation 5 ☐ Other (Specify	nemoval nom State	smotory, crem	iatory or other place	5)			
all all	Departr Importa any Inj once.		21. Signature of Funeral Service Licens Ronal S.	Wade, Director	22	Name and Addres	ss of Facility	GEE 11	D = 1 ± 2	
u a	6 5 2 0		1 tomas /	// (Sell	−−†Ba	ltimore,	MD 2120	01		e Street
P)	nysician		23a. Part L. Enter the disease, or comp shock, or heart failure. List only of Immediate Juse (Final disease or condition	lications that caused the death one cause on each line.		er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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uted	ınsit	mine	Sequentially list conditions, if cause. Enter Underlying Cause (Disease or injury that initiated events	State to for each por secon	erioa utj:					
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ath ce	attending p for use as	sician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal	death 3□	Ectopic pregnancy	/		23d. Date o	
The law requires that the death certif	the s	ysic	1 □ Yes 2 XNo 9 □ Unknown	4 ☐ Pregnant at time of do 9 ☐ Unknown	eath 5□	Other (specify)			, World	Day real
that	ned by the a	y Phy	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
v requires t	s been signed t	d by	HYPERTENSION	/				1 □ Ye	s 2 No 3[☐ Probably 4 ☐ Unknown
aw re	has bee	Completed	OSTEO POROSIS					24a. Was ar		re autopsy findings available
r Per	ate ha	mo	HYPER LIPIDEM	iA				autops perform 1 🗆 Yes 2	prio ned? dea	or to completion of cause of th? Yes 2XNo
cian;	his certificate ha I director, page 2	Be	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only one		1163 2 A NO
Physi	this c	2	1 les 2 140	Hospital: 1 ☐ Inpatient 2 ☐ I			4 LI Nursing Ho	ome 5 Reside		(Specify) HOSPICE
Attending Physician;	h. After th funeral	tion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work M 1 □	/ at ? /es 2 □ No	28d. Describe ho	w injury occurred	
Atten	r dear	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury At ho	me, farm, stre		103 E	28f. Location (Sti	eet and Number o	or Rural Route Number,
2 5	s afte	Certification:	4 ☐ Homicide determined	building, etc. (Specify	")			City or Town	, State)	,
ne Hospil	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edical	29a. Certifier (Check only one) Certifying Phy Medical Exam	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tin restigation, in my op	ne, date and place pinion, death occur	, and due to the carred at the time, da	ause(s) and mann ate and place, and	ner as stated. If due to the cause(s)
To #	To tl	M	29b. Signature and title of certifier	6		29c. License		29	d. Date signed (A	Month, Day, Year)
			/ CARRY	MU		DAD	54-4	1	1/5/200	9
				ompleted cause of death (Item	23a) (Type, F	Print)	344 #220 B	(10 To a K: //	15 110	20011
	Stat		ROBERT J. G/1861: 31. Date filed (Month, Day, Year)	2. Registrar's Signal		PRIVE	TCCO D	UKIUN3416	LO, MU	SUXXX
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Registrar
DHMH 17 Rev 1/2001

			1- State of Maryland Der me, g901,0372	partment of Health and I 6/2010 dnb, 25 ertificate of Death	Mental Hygi	ene				
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year				
	/Medi		Carol Watkins	<u></u>	Novembe	PR 4,2009 3:10 AM				
	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death Prince George's				
	Francis		Doctor's Community Hospital 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthda	Lanham If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign				
	Funeral Director		1□ M 2	Months Days Hours Min.	(Month, Day,	949 Country) unk				
	pt ,		Usual Residence of Decedent		Juli 1, 1	J-13				
	arylar show	<u>=</u>	10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits				
	he Ma 28a-f	ecto	MD Prince George's Lanham		T	1 ☐ Yes 2V No				
	a or	흐	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?				
	ns 23	Funeral Director	9023 Annapolis Road 11. Marital Status unk 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origins (S	pecify Ves or No-	USA 14. Race - American Indian,				
980	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, the Madical Exemirer input the notified at	ò	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No unk 3 Widowed 4 Divorced Year or Dates:	. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc. Specify: White				
15-0		Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)		6b. Kind of Business/Industry unk				
212	filed withir I Hygiene. other than ent, Inc. M	Somp	Elementary/Secondary (0-12) unk College (1-4or 5+)	DO NOT use remedy						
land	0 70 5	To Be (17. Father's Name (First, Middle, Last)	unk 18. Mother's Nam	ne (First, Middle, Ma	aiden Surname) unk				
Jary	12 should be fi h and Mental H is marked ot traumatic ever			ing Address (Street and Number or Ru	,					
e, l	ss 1 and 2 soft Health a litem 27 is			8 Goodluck Road L						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any liqury or other traumatic esones.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state	osition (Name of matory or other place)	Date 26	0c. Location - City or Town, State				
Ball	permit Depart Import any In			Zale addacomy aggard altimore, MD 2120		Baltimore Street				
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- Alexandria	/Medical Examiner	ler	Due to (or as a consequence of):	^		1/2				
	icate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Probable Stroke	\cap	11/6	STOCAL EXAMINER				
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O. Box 6	ath certifi attending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	23d. Date of delivery Month Day Year						
ds, P.	ires that the de signed by the a	by Ph	Part II. Other algnificant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?				
So	w requir	etec	200							
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ion	nding ath. r: Afte e fune	atior	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? M 1 □Yes 2 □No	20d. Describe now	ringury occurred				
Divis	al or Atte s after dea Il Directo ed in by th	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal can be best of examination and/or i and manner stated.	th occurred at the time, date and place ovestigation, in my opinion, death occur	, and due to the car red at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)				
	To th To th COMP	Me	29b. Signature and title of pertifier	29c. License number	290	d. Date signed (Month, Day, Year)				
			My Cha	D6155Z		11/04/09				
			30. Name and address of person who completed cause of death (Item 23a) (Type Kevin K. Erfan, mi). \$118 600	Print) Luck Rd. (anhaw	11/04/09 1, MD. 20106				
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 3 2009			1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 2009 Richard John Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Homewood Genesis N/A 9. Birthplace (State or Foreign Country) M D Balto 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7-29-1939 **Funeral** 1 M 2□ F Months Davs Hours Min. 70 Director 213-34-8904 MD Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County ral", or items 23a or 28a-f show Examirer must be notified at 1 TyYes 2 □ No **Funeral Director** MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1700 N.Gay Street Apt 228 21213 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 XYes 2 □ No 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black \$ "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Arbutus Cleaning Janitor 10th grade n/a and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John L. Williams Virginia Kindall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda Williams -Sister 5497 Bucknell Road Pages 1 and 2 Health a Balto, MD 21206 : If item ? 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ŏ permit. Page: Department o Important: If i any Injury or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-9-2009 Balto Co, MD Garden of Faith 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD21202 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, HIL Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner and burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 Yes 2 No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes WNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed funeral After t 24 hours after death e Funeral Director:

completely filled in by To the I within 2

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

and manner stated.

investigation

6 Could not be determined

and title of certifier

2 Accident

3 Suicide

29a. Certifier (Check only

29b. Signatu

one)

4 Homicide

Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Wortham Woods Road. MD 21234

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, f, perFH, G897, 11, 13, 109, WS
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month PHYLLIS WELSH NOV 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Howard County General Columbia Hospital Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Union Bridge 1 ☐ Yes 2 No 530 Shriner Ct 10e. Street and Number 10f. Zip Code 21791 10g. Citizen of What Country? 484 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2**X** No Specify Specify: white 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Nurse Practitioner Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald E. Zahniser Isabel Elizabeth Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Welsh-son 6 Westmoreland St., Westminster, MD 21157 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State South Carroll Crem. 11-8-09 | Winfield, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signatur of Funeral Service Licens 254 E. Main St., Westminster, MD, 21157 homas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □ Yes 2 🗆 Ak 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred on 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the attending physician the signed by the atte

After this certificate

death.

within 24 hours after death To the Funeral Director:

Physician

/Medical

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, III

Funeral Director

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical 2 Completed Be Certification: To

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Part II. Other significant co	nditions o
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1 Yes 2 I	0
27. Manner of Death	
1 Natural	5 Pending
2 ☐ Accident	investigation
3 Suicide	6 Could not

6 Could not be determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

29a, Certifier

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

an

Howard Courty Genera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of	Marylan					nd M	lental Hygi	_	0.00	
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· wage	/Medic Examin		4a. Facility Name (If not institution, give		ampl	110	4b. City, To	wn. or L	ocation of		MOVEMBEL		unty of Death	11.20 11
and the second	Examin	ei	13851 St. Bened				Union			Dodin			derick	
	Funeral		5. Social Security Number 6. Se	ex	7. Age (In yrs.	last birthday)	If Under 1		If Under 2		8. Date of Birth (Month, Day,	Vea rl	9. Birth	place (State or Foreign ntry)
	Director		149-01-9083	⊒м ж ТХт г	89	Yrs.	Wonths	ays	Hours	Min.	06/08/	1920	Cou	NY.
	and w		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	ration							10d. Inside City Limits
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	the N	Director	10e. Street and Number	LCK		UIIIOII	10f. Zip Co				10	a. Citizen	of What Cou	ntrv?
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	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Evaninger must be notified at	Funeral	11. Marital Status		dent Ever in U.	S. 13. V	Vas Deceden			in? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ameri	
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Maryland 21215-0036	2 should be f n and Mental is marked o raumatic eve	To B	Walter Williams						М	li1d:	red Alle	n		
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≥ .	and lealth m 27 her tr		Philip Zampino/S	on							, Union			
Baltimore,	ges 1 If of F If ite or ot		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □	Removal from 5	State 20b. F	Place of Disposemetery, cren	sition (<i>Name</i> natory or othe	of er place)		D	ate 2	Oc. Locat	ion - City or To	own, State
ţ	tt. Pa rtmer rtant: rjury	74	4 □ Donation 5 □ Other (Specify		Res					11,	/16/2009	Fre	ederic	k, MD.
Ba	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature V Funeral Service Licens	au	4	Bu 12	Name and A rrier- 12 Wes	Que Ct 0	en Fu Id Li	nera	al Home	k Cre	ematory ield, N	P.A. 10. 21784
			23a. Part . Ent r the disease, or comp sh/ck, or leart failure. List only o	lications that cannot cause on ea	aused the deat	h. Do not ente	er the mode o	of dying,	such as c	ardiac o	r respiratory arres	st,		Approximate Interval Between
4	Physician		Immed ate Cav e (Final diseas √or co dition	. / [_eut	emi	0							Onset and Death
	/Medical Examiner		resulting Teath)	Due to (or as a conseq	uence of):								
	_xammer	<u>.</u>	Sequentially list conditions,	b. Due to (or as a consequ	uonoo of\:							-	
	nsit	ij	if any, leading to immediate cause. Enter Underlying Cause Unleade or in jury that initiated events	Due to (or as a corrsequ	derice or,.								
ć	exection and ial-tra	Examiner	resulting in death) Last	C. Due to (or as a conseq	uence of):								,
8760,	ficate be executed physician and s the burial-transit	dical		d										
9	ng ph as th	Med	IF FEMALE:									1		
Вох	ath ce ttendi or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo 1 ☐ Live b	come of pregna		Ectopic preg	nancy				23d	. Date of deliv	,
0	the a	Physician/Me	1 Yes 2 No	4 ☐ Pregn 9 ☐ Unkno	ant at time of c own	leath 5	Other (speci	ify)					WOTH	Day Year
P.0.	that the ed by detac	F	Part II. Other significant conditions co	ntributina to de	ath but not res	ultina in the un	deriving caus	e given	in Part I.		23e. Did toba	cco use	contribute to t	he cause of death?
Division of Vital Records,	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Completed by					, ,				1 □ Yes	212 K	lo 3□ Pro	bably 4 ☐ Unknown
SCO	law re as bee 2 shor	olete									24a. Was an	2	4b. Were auto	ppsy findings available
Ĕ	The lav ate has bage 2 a	E O									autopsy performe 1 □ Yes 2	gi? SINo	prior to co death? 1 Yes	ompletion of cause of
ita	ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?					2	26. Place o	of Death	(Check only one,		7 🗆 103	2010
<u>></u>	tending Physician: The leath. ior: After this certificate hat the funeral director, page		1 ☐ Yes 2 No		npatient 2 🗆	ER/Outpatien	t 3□DOA	Other:	4 ☐ Nurs	sing Hor	ne 5 Residen	ce 6 🗀	Other (Speci	fy)
n c	ding F	ö	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of	of Injury h, <i>Day, Year)</i>	28b. Time of Injury		Injury a Work?			8d. Describe how	injury o	curred	
<u>s</u>	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	280 Place	of Injury - At ho	me form etre	M		s 2⊡No		8f. Location (Stre	et and N	umbas on Dur	al Boute Number
<u>≥</u>	after death after death Director: d in by the	Certification: To	4 ☐ Homicide determined	buildir	g, etc. (Specif	y)	et, lactory, or	lice		'	City or Town,	State)	umber or Aur	ar noute Number,
	hou hou ly fill		29a. Certifier 1 Certifying Phy	siclan: To the	best of my kno	wledge, death	occurred at	the time	, date and	l place, a	and due to the ca	use(s) an	d manner as	stated.
í	To the He within 24 To the Fu complete	Medical	(Check only 2 Medical Exam	and mann	er stated.	non and/or inv				occurre				
	To To I	≥	29b. Signature and title of certifier				29c. L	icense r	number		29	d. Date si	igned (Month,	Day, Year)
•			MTolen	> /	W		M	25	1610			47"	409	
			30. Name and address of person who c	ompleted cause	of death (Item	1 23a) (Type, F	Print)	A	10	h	2/7/	7.		
	Sta	e	31. Date filed (Month, Day) Year)	32. Re	gistrars Signa	ture .	1.4	FU	/	4	- 1 10			
	Registra		WAY TRUE A	Karna	13. A	ankal								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 36490

audia S. Alex	ana	1- For State Certific	ate of Death	Reg	g. No.	
Physic ledical Exam		1. Decedent's Name (First, Middle,Last)		Date of Death Month October 31		3. Time of Death 1848 hrs
euicai Exaii	mei	Claudia S. Alexander 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		, 2009 4c. County of Deat	
		Washington Adventist Hospital	Takoma Park	•	Montgomery	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last bir			(MM/DD/YYYY) 9. Bi	
Directo		577-68-9909 1 M 2 XF 57	Yrs. Months Days Hours Min	Nov.25	5,1951 Forei	ountry) DC
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
*			sville			1XXYes 2 No
ne Maryland or 28a-f show fred at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?
the M a or 2	<u>i</u>	5645 Sargent Road	20782		USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S			rican Indian, Black,
r death or ite	E	1 Yes 2 V No		rrican, etc.)		
rs afte ural",	<u>چ</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind of	work done	Specify: B1 16b. Kind of Business	ack /Industry
2 hou "nati	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret		Top. Tana of Sacritoso	, madda y
036 ithin 7 me. r than	Comple	12	Child Care Provid	er	Private	Industry
5-0 iled w Hygie Jothe	ြပ္ပိ	17. Father's Name (First, Middle, Last)		e (First, Middle, M	,	
121 Id be f Aental narke	Be .	Claude D. Simon	Barbar 1b. Mailing Address (Street and Number or	a E. Pe	erry	o Zin Code D O O O C
L Shou and N	P		19417 Brassie Pl.			
e, N I and Health item		20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery,	Date	20c. Location - City of	
nor Pages ent of nt: If		T Durial 2 Cremation 3 Removal nom State	tory or other place)	10.00	Riverdal	e.MD
altir mit.] partm porta		21. Signature of Funeral Service Licensee	22. Name and Address of Facility La			
W 8 9 E	<u>'</u>	CC0278	3831 Georgia A	ve. NW	Wash.,DC	
Physiciar		23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.				Approximate Interval Between Onset and
xamine		Immediate Cause (Final disease or condition resulting in death)) and tricyclic anti mitriptyline & nortr	depressa	ant hintoxic	Death
		Sequentially list conditions, b.	micriptyllne a north	трсутти) Inconte	
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ecuted and transit	<u>a</u>	d.				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and nane 2 should be detached for use as the burial - trans	Medical	X UNPENDED AMENDED 23a,27,28a	-f,permE, g897 11/20	/09 TT		
lox 68760, eath certificate be ex attending physician for use as the burial.		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	2 Fetal death 3 Ectopic pregn	ancv	23d. Date of delive Month	ry Day Year
Box 687 death certific the attending p	icia	past 12 months? 4 Pregnant at time of death	5 Other (Specify)			•
Bc he dea y the a	Physician/	Yes 2 ✓ No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23a Did to	bacco use contribute t	o the cause of death?
ires that the signed by a signed by a feetache	5	Fait ii. Other significant conditions — contributing to death but not resulting	ig in the underlying cause given in Part I.		2 ✓ No 3 Pr	
rds, require been sig	sted			24a. Was a		autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir as after death. al Director: After this certificate has been seed in by the funeral director, page 2 should led in by the funeral director, page 2 should	Completed			autops perfor	med? death?	
tal Reciant The certificate	ပ္သ	25. Was case referred to medical	26.Place of Death (Check		2 No 1 \ \ \ \	Yes 2 No
Vital ysician: his certif director,		examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/C	Othon		Residence 6 Oth	er:
Of Ing Ph	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury 28c. Injury at Work?	1 -	ow injury occurred	
Sion vttendi death. ctor:	aţie	Natural 5 Pending Fd 10/31/09 Fd	5:30 pm 1 Yes 2 X No	unk		
Division Atthorns after de nours aft	Certification:	3 Suicide 6 X Could not be determined (Specify) found at	farm, street, factory, office building, etc.	or Town, St	tate)	Rural Route Number, City
E & E		29a. Certifier				attsville, M
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or				
To To	Mec	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	lonth, Day, Year)
		Tell letter leek 178	O.C.M.E.		November 1, 20	009
		30. Name and address of person who completed cause of death (Item 23a)			L	
		Victor Weedn MD JD Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201		
Regi	State	INDIVITION TO THE TOTAL AND THE	pares			

State of Maryland / Department of Health and Mental Hygiene 2000

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			For State Registrar	State of Mar	yland / L	Certif	icate of D	eaith and iv	ieritai my	Reg. N	2009	36491	
	Physici	an	1. Decedent's Name (First, Middle, Last)	Sue Ald	la tima a				2. Date of Dea Month October		2009 2009	3. Time of Death 8:15 am	
/Medica Examine			4a. Facility Name (If not institution, give str	4b	4b. City, Town, or Location of Death			4c. County of Death					
	Exami	lei	Holy Cross Hos				,	ier Sprin	ıg		Montgo	mery	
	Funeral Director	Г	213-80-0307	7. Age	(In yrs. last birt		Under 1 Year onths Days	Hours Min.	8. Date of Birt (Month, Da 12/09/	h y, Year 19 6	9. Birth Cou	place (State or Foreign intry) th Carolina	
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Towr	or Location	on					10d. Inside City Limits	
	a-fsh	ctor	Maryland Montgome	ery			Si	lver Spr	ing			1⊠Yes 2 No	
	or 28	Dire	10e. Street and Number			1	0f. Zip Code			10g. C	itizen of What Cou	-	
	eath v	eral	11026 Hemingway	Cowrt 2. Was Decedent Ev	er in U.S.	13 Was		20902	ecify Yes or No	. 1	U.S		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Evarinar must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 💆 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				panic Origin? (Spo , Mexican, Puerto Specify:	Rican, etc.)		Black, White		
5-0	72 ho 'natur	eted	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a.	(Give kind	's Usual Occupat of work done du	tion Iring most of worki	ing	16b. I	Kind of Business/li	ndustry	
121	e filed within al Hygiene. I other than "vent, I'c Me	ршс	Elementary/Secondary (0-12)	College (1-4or 5+)	Pe		NOT use retired) el. Mamt	. Special	ist	Fed	deral Gov	vernment	
d 2	be filed stal Hygi od other event, I	BeC	17. Father's Name (First, Middle, Last)		1,0			18. Mother's Name	(First, Middle,	Maide	n Surname)		
ylar	2 should be and Mental is marked craumatic ev	To E	Ronald C. Ald	erman				(Carolyn	Wor	irell		
Var	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type	*	I .					_	or Town, State, Z		
	1 and 2 Health tem 27 i		Carolyn Alderman - 20a. Method of Disposition	<u> mozner</u>			emungwal n (Name of ry or other place)		Date		ring, MD Location - City or T		
E G	Pages sent of nt: If Ii		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	noval from State					2/2009	Вл	entwood.	Maryland	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or of		21. Signature of Funeral Service Licen e	Ten by		22. Na	ame and Address	of Facility Hiv	res-Rino	ald	i Funeral	Home, Inc. ring, MD2090	
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the	ne death. Do r			•		·		Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Lupus								Onset and Death	
4	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):							
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60,	tificate be executed ig physician and as the burial-transit	E E	resulting in death) Last	Due to (or as a	consequence o	of):							
68760,	ficate g phys	edical	d.						-				
P.O. Box	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/N	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒No 9 □Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal death		topic pregnancy her (specify)				23d. Date of deli Month	very Day Ye ar	
	s that gned b e deta	by Ph	Part II. Other significant conditions contr	ibuting to death but	not resulting in	the under	lying cause giver	n in Part I.	23e. Did to	obacco	use contribute to	the cause of death?	
ord	w requires to been signer should be	ted k				_			1 🗆 \	res a	2 X No 3 □ Pro	obably 4 Unknown	
Division of Vital Records,	: The law i cate has b , page 2 sh	Comple	Completed							24a. Was autop perfo 1 □ Yes	osy rmed?	prior to death?	topsy findings available completion of cause of 2 ☐No
V:	Physician; The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	spital:	0 PM EDIO		Othor	26. Place of Death			a E 011 12		
10	g Phys er this eral di	n:To	27. Manner of Death	28a. Date of Injury (Month, Day,	t 2 🖾 ER/Ou	ime of	28c. Injury Work?	4 LI Nursing Ho	me 5 🔲 Hesii 28d. Describe I		6 ☐ Other (Specury occurred	cify)	
sion	Attending For death. ector: After by the funera	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day,	rear) II	njury		es 2 □ No					
Σ. Σ.	or Att after de Direct in by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, fai <i>(Specify)</i>	rm, street,	factory, office		28f. Location (: City or To		and Number or Ru te)	ral Route Number,	
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) 1 ☐ Certifying Physl 2 ☐ Medical Examine		examination an								
	To the within 2 To the comple	Me	29b. Signature and title of centifier	M			29c. License	number		29d. D	ate signed (Month	n, Day, Year)	
	6		> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	white	1		11005	1280			10-28	2009	
	٦		30. Name and address of person who com	pleted cause of dea	ath (Item 23a) (Type, Prin	t)		+ #001			•	
	Sta	te.	Anushiravan Dadga 31. Date filed (Month, Day, Year)	パーレeれたのたの 32 Registrar'	's Signature —	., 10	TIU MOR	ecular V	7. #206,	KUC	RVICLE, I	VID 20850	
	Registr		OCT 3 0 2009	32 Registrar	J	park	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Stin tober23 2009 mper City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Baltimere Hrs. 6. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number last birthday Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🖫 F 56 338-48-1825 Jan. 23, 1953 Illinois Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 305 Heathfield Lane 21403 U.S.A.

1 ∐Yes 2**∑**No

305 Heathfield Lane

20b. Place of Disposition (Name of cemetery, crematory or other place)

16a. Decedent's Usual Occupation

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

(Give kind of work done during most of working life. DO NOT use retired)

Senior Auditor

14. Race - American Indian,

White

Approximate Interval Between Onset and Death

Black White, etc.

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

Annapolis, Maryland

June M. Day

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Baltimore Crematory 10/29/2009 | Baltimore, Maryland

16b. Kind of Business/Industry

U.S. Senate

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

Physician /Medical

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

11. Marital Status

1 ☐ Never Married 2X Married

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Malcolm P. Austin

Tom Lippert/husband

4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type. Print)

Funeral

Director

28a-f show

or items 23a or death with

Director

Funeral

ð

Completed

Be

2

event, the Medical Examiner must be notified at

the Maryland

Baltimore, Maryland 21215-0036

and attending physician for use as the burial the signed by been : has this certificate After thi death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten may Injury or other traumatic event, the Medical Exercited page. 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PSIS Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O 2 1 ☐ Yes 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Leath 28a Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

12. Was Decedent Ever in U.S Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

Registrar

600 N. Wolfe St. Baltimore MD 21287 Bueso M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B

31. Date filed (Month, Day, Year) OCT 2

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28 2009 Geraldine Ader October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9930 Carrigan Drive Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 03-04-193 Director 213 28 0807 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9930 Carrigan Drive 21042 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with. Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic permits once. 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Goldbeck Julia Falk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Ader/Husband 9930 Carrigan Drive Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 11-2-2009 Hanover, MD Signature of Funeral Service Licensee M01044 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Antonoschorolic CAndio vuscula Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Examine Physician/Medical Completed by

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Records, P.O. Box 68760 Division of Vital

Be

Certificate: To

Medical

only one) 29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ken Williams 2801 Foster Avenue Baltimore, MD 21224 egistrar's Signatur

Sequentially list conditions,	b. ————————————————————————————————————				
if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence of):				
resulting in death) Last	Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?			
		1 Yes 2 No 3 Probably 4 M Unknown			
		24a. Was an autopsy speriormed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
25. Was case referred to medical	26. Place of Death (Check	only one)			
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 XResidence 6 Other (Specify)			
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigatic 3 □ Suicide 6 □ Could not I	n (Month, Day, Year) Injury work? M 1 Tes 2 No	8d. Describe how injury occurred			
4 Homicide determined	178e Place of Injury - At home tarm street tactory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at t se Practioner: To the best of my knowledge, death occurred at the time, date and place	he time, date and place, and due to the cause(s) and manner stated			

D3344P

36493

3. Time of Death

10d. Inside City Limits

Interval Between Onset and Death

29d. Date signed (Month, Day, Year)

October 29, 2009

1 Yes 2 XNo

6:15 P M

10 State

Registrar DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Worth. 25^{Day} 2009^{ear} 11:57 A.M **BOMZER** Estie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner #1504W Chevy Chase Montgomery 4620 North Park Ave. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Bay, June 20, 9. Birthplace (State or Foreign New Tyork 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Year) 930 1 □ M 2 🕡 F 092-24-6287 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examination must be not titled at Director 1 ☐ Yes 2 X No Chevy Chase Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 U.S.A. 4620 North Park Ave. #1504W Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∭No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No δ Specify. White 3 ℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) University's Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pauline Kuperstein Lipman Sidney ျ 19b. Mailing Address (Street and Number or Flural Boute Number, City or Town, State Zip Code)
9 Climbing Rose Court, Rockville, Md 20850 19a. Informant's Name/Relationship (Type. Print) Sue Alterman / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 27, 2009 Pinelawn, NY Beth Moses Cemetery 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral erval 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or se à concequence of) Examiner be executed Hyperlipidemia burial-tran Due to (or as a consequence of): P.O. Box 68760, ing physician e a as the burial-Physician/Medical Tobacco Dependence attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) ∃Yes 2 X No 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **X**No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edic xa Iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 26, 2009 D0053711 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave., Chevy Chase, Md <u>Pasquale Santini,</u> 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 30 2009 Registrar

09-08558 Roy Scott Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Physicia	an/	1-For State Amend#196 Per FH Registrar 11/6/09AACO HFAITH DEPT OM Certifi 1. Decedent's Name (First, Middle, Last) Roy Scott Brown	icate of Death	Reg. No. 2. Date of Death Month Day Year 0730 N	
l Exami	mer	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	Month Day Year 0720 I	nrs
		623 Tuckahoe Creek Court	Annapolis	Anne Arundel	
uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last t	birthday) If Under 1 Year If Under 24Hr		te or
irector		220-84-2808 1 M 2 F 4	40 Yrs. Months Days Hours Min	Apr 18 1969 Manny la	nd
any			wn or Location	10d. Inside	
28a-f show d at once.	<u>_</u>	Maryland Anne Arundel Arm	nold	1 Yes	2 X N
28a-f d at o	Direct	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
23a or 28a-f sho notified at once.	Ö	41 Old Frederick Rd.	21012	USA	
or items 2 nust be n	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		Black,
ral",	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2X No specify:	Specify: Black	
'natu Exan	ted	15. Decedent's Education (Specify only highest grade completed) 16 Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re 		
Heath and Mental Hygiene, item 23a or 28a-f she ream 21 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	Completed	12th 0	Contractor	Self Employe	d
Hyg d oth		17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
Menta	To Be	Roy Scott Brown 19a. Informant's Name/Relationship (Type, Print)		y Hunt Rural Route Number, City or Town, State, Zip Code	1061
27 is matic	-	1 ,		ace Apt 104 Glen Bur	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 X Buriel 2 Cremation 3 Permayal from State Crem	⊉ df Di-இற்று tegres Name of cemetery, natory or other place) Orial Gardens 11	Date 20c. Location - City or Town, State -11-09 Annapolis, M	
rtmen rtant y or o		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		s Mortuary, P.A.	
Depa fmpd injur				napolis, Md. 21401	
sician		Farry J. Assemble 83 3a. Part I nter the disease, or complications that caused the death. Do		or respiratory arrest, shock, or heart Approxim	ate Interva
edical iminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	cation		Onset and eath
	_	Sequentially list conditions, b.			
	nine	if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of):			
nd ransit	I Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
physician and the burial - trans	Medical	X UNPENDED AMENDED 23a.27.28a	a-f,permE, g897 11/16	/09 TT	
	_ =	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth	cy 2 Fetal death 3 Ectopic pregn	23d. Date of delivery	Year
the atten	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)		
signed by the attending be detached for use as	by	Part II. Other significant conditions contributing to death but not resul	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of	
Division of Vital Records, P.O. Box 68 ta la or Attending Physician: The law requires that the death certif ar after death. The law forcer: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as				24a. Was an autopsy performed? 24b. Were autopsy finding prior to completion o death?	
After this certificate I funeral director, page	Completed	35. Was assa referred to madical	00 Diagraf Death (Observe	1 ✓ Yes 2 No 1 ✓ Yes 2	No
s cert irecto	a	25. Was case referred to medical examiner? Hospital: I Inpatient 2 ER	26.Place of Death (Check //Outpatient 3 DOA Other;	ng Home 5 Residence 6 V Other: Scene	
After th	- To	27. Manner of Death 28a. Date of Injury 28	b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ath he fur	tion	Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 11/4/09	1 7:00 am	unk	
rs after de al Directo led in by t	Certification		e, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number or Town, State) 623 Tuckahoe CCt. Annapolis, MD	umber, City
within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/or		d due to the cause(s) and manner as stated.	
To Con	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yea	ar)
	50	ufler Brasel Mid	O.C.M.E.	November 4, 2009	
141					
A (30. Name and address of person who completed cause of death (Item 23a Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, partier) 32. Registra's Sign for a sign for	·	21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36496 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death BASSFORD Physician/ Mont 341 M ARLES Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** M 2 □ F Months Days Hours Min 1977771938 219-26-9845 Director 71 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXVo MD Anne Arundel Davidsonville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1152 Double Gate Rd. 21035 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2x Married 1 Yes 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo White "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CEO Wholesale Distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Bell Bassford Louise Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Bassford Spouse 1152 Double Gate RD. Davidsonville, MD 21035 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville UM Cem 10/31/2009 Davidsonville, MD Servige Linnsee 22. Name and Address of Facility Hardesty Funeral Home, P.A. . Signature of Fundral 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician OLDS TATE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of Cause (Disease or iinjury The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear Pregnant at time of death ate has been signed by the a page 2 should be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 🗌 Yes 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate Yes the Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) ANDRIN Other: 1 Yes 2 🗷 No HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 11041 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of XH

Registrar DHMH 17 Rev 7/2009

State

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M 441

egistrar's Signature

MO 21401

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

32

nth, Day, Year)

31. Date filed (Month,

			Please	Type or Print in State of Maryla					-		9	
			1 - State Registrar		Ce	rtifica	te of	Death		Reg. No.	2000	261.0
			1. Decedent's Name (First, Middle, La	st)					2. Date of D		L 0 0 3	3. Time of Deam
	Physici /Medio		Lois Buckel								24 2004	6:05-AM
	Examin		4a. Facility Name (If not institution, give			4b. City	, Town, o	r Location of Deat	h	4c.	County of Death	1
-			Futurecare Chesa 5. Social Security Number 6. S		n last high days	If Inde	Arr. er 1 Year	old If Under 24 Hrs.	O Data of D	imate	Anne A	
	Funeral Director		041-24-7821	1 M 2 XF 7. Age (in y)	s. last birthday) Yrs.	Months		Hours Min.	8. Date of B	26, 1	931 Con	pplace (State or Foreign Intry) Necticut
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation						10d. Inside City Limits
	r 28a-f show	ō			everna 1							1 ☐ Yes 2 XNo
	7.28a	Director	10e. Street and Number			10f. Zi	p Code			10g. Cit	izen of What Cou	intry?
3	23a or	a D	242 Charita Way				21	146			US	A
15-UU36 n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show water Expressions to a continued at		by Funeral	11. Marital Status 1 ☐ Never Married 2 【★ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 □Yes		lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	lo-	14. Race - Amer Black, White, Specify: Wh	etc.
5-0036	natura inal	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usu	al Occup	ation	14	16b. Ki	ind of Business/li	ndustry
121	withi	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12	College (1-4or 5+)	i _			during most of wor ealtor	King		cis Coil cate Com	
_	~ = 0 %	Be	17. Father's Name (First, Middle, Last, Howard Hendsey)				18. Mother's Nar		e, Maiden	Surname)	
<u> </u>	z snould be and Menta Is marked aumatic ev	은						Mary				
Na Na	thand 7 Is n traun		19a. Informant's Name/Relationship (Jerome Buckel/Hus			ng Addres 2 Cha		and Number or Ru		-		
υ .	Healt Healt em 2		20a. Method of Disposition						Date		MD 211	
aitimore	permit. Fages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic evonce.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inellioval Irolli State Mr	Place of Dispo cemetery, crer Vetera	natory or o	other place Ceme	tery Oct	. 28,		wnsvill	
gall	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licer	nsee	22 Pa	2. Name a	nd Addre	ss of Facility Sons, P itchie Hy	Λ Sα	vorns	Dark E	unoral Homo
P	hysician /Medical xaminer		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Con G C Due to (or as a conso	ath. Do not ent	ter the mo	de of dyir	ng, such as cardia	or respiratory	arrest,	Park,	uneral Home MD 21146 Approximate Interval Between Onset and Death
70	isit isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
5875U,	cia	lical Examiner	that initiated events resulting in death) Last	c	equence of):							
C. Box 68	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	tal death 3 [☐ Ectopic ☐ Other (s		у			23d. Date of deli Month	very Day Year
7, the	med t	by PI	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying	cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
	annsigna an signa and pin	ed b	END STAGE	RENAL F	AILU	RE			1 🗆	Yes 3	Z ^{No} 3□ Pro	obably 4 🗌 Unknown
VIIII RECORDS,	ate has bei	Completed							per	s an opsy formed? 2 \(\int \(\text{No} \)	prior to c death?	opsy findings available ompletion of cause of
/11a	ertific sctor,	Be (25. Was case referred to medical examiner?					26. Place of Dea	ith (Check only	one)		
0	this c	၉	1 Yes 2 1 No	Hospital: 1 Inpatient 2				4 Lydnursing F	T		6 □ Other (Spec	ify)
o uoi	ath. It: After ne funera	ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		М	28c. Injury at Work? M 1 Yes 2 No		28d. Describe how injury occurred			
DIVISI February	rs after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)			eet, factor	y, office		28f. Location City or To	(Street and Number or Rural Route Number, own, State)		
Hoen	e Funer	Medical		nysician: To the best of my k niner: On the basis of exami and manner stated.								
Ž.	vithin comp	Me	29b. Signature and title of certifier		·	29	c. Licens	e number		29d. Da	te signed (Month	, Day, Year)
			> msnegi	, mix		1	D5-	7531		607	SBER 2	26,2009
^	16		30. Name and address of person who	completed cause of death (It	em 23a) (Type,	Print)				-		
()	ナン		mobile Nep	. 8601 Vet	Vens !	Hur	1 1	ente 20	yn	illes	revile.	M) 21/49
	Sta Registr		30. Name and address of person who Month, Day, Year OCT 29	2009 Skewistrar's Sig	A. A.	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** Sarah Edna Blank :05AM October /Medical 4a. Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HIMOTE les has ONS WO 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 216-32-2371 101 Director Maryland Apr. 06, 1908 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f show Baltimore MD Catonsville 1 ☐Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e. Street and Number Care Center 709 Maiden Choice Lane, South 118 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No ģ Specify: Specify: 3 ₩ Widowed 4 □ Divorced th and Mental Hygiene.
7 is marked other than "natural", traumatic event, its ["odical Ex-Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Drapery Salesperson Montgomery Ward 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be Thomas Tydings Annie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Catherine E. Wheeler/ Daughter 461 Mason Lane Arnold, MD 21012 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Glen Haven Memorial Park Oct. 2 2009 Department or Important: If any injury or once. = 6 1 XBurial 2 ☐ Cremation 3 ☐ Removal Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Fun and Service Licensee Rarranco Ritchie Hwy, Severna Park, MD 21146 P.A. Severna Park Funeral Home 23a, Part*. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only/one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Rar disease or condition r sulting in death) /Medical Due to (or as a consequence of): **Examiner** equentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d, Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 1 □Yes 2 1 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 | Yes 2 | 1 | No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

State

29b. Signature and title

30. Name and addre

31. Date filed (Month, Day,

Registrar DHMH 17 Rev 1/2001 Maide

who completed cause of death (Item 23a) (Type, Print)

N6

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Russell Eugene Boone, Jr. 2009 0908 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) Jan 10, 1982 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Mary land 1**™**M 2□ F 216-98-6130 27 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Westminster Director Maryland Carroll 1 ☐ Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21158 USA 1436 High Street Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other the any injury or other trainments. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 11. Marital Status 14. Bace - American Indian. 1 XNever Married 2 ☐ Married 1 ☐Yes 2 🗙 No Specify: white If Yes, Give T Year or Dates: \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Louise Thomas Russell E. Boone ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Boone, mother 1436 High Street, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2009 Westminster, MD John Luther Miller 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ature ρf Funeral Service Licensee Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the page to the busical tension. Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 2009

State Registrar

31. Date filed (Month, Day,

30. Name and address of person where mpleted cause of death (Item 23a) (Type, Print)

Year)

295

32. Rea

Amend Item 18 per F.D. 10/27/09 Carroll County, will State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Junabeth W. Brunson 25 October | 2009 12:10 a[™] /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Summerville at Westminster Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. 86 Illinois Director 492-32-4600 Nov 09 1922 Usual Residence of Decedent Maryland 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location in than "natural", or Itams 23a or 28e-f show the Madical Examinary was be restilled at Director 1 XYes 2 No MD Carroll Westminster with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Washington Road 21157 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hyglene. ant: If Item 27 is marked other than "naturat", or Ite ary or other traumatic event, Ita M. Aucal Esta uits ary or other traumatic event, Ita M. Aucal Esta uits Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Weatherford Mollie Mansker Mary Jane Mansker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred W. Brunson, Jr/son 47-160 lulu, Kaneohe, Hawaii 96744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Valhalla Cemetery 10/30/2009 Belleville, MO 21. Signature of Funeral Service Licensee Pritts Funeration and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the attending physicien and hed for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? res No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ۵ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Assist funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No filled in by the t 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number WIL eted cause of death (Item 23a) (Type, Print) address of person 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 Registrar